

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11566					11577				
1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Friendship Manor Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 2408 Marsh Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Bessie Middle M. Last Alexander			4. DATE OF DEATH Month August Day 22 Year 19 67						
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/1897	9. AGE (in years last birthday) 70 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Rouzeville, Franklin Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry J. Martin			14. MOTHER'S MAIDEN NAME Molly Sheldon						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 216-01-6243		17. INFORMANT Address B Arthur M. Alexander Hagerstown, Md. #6				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis, cerebral & generalized with chronic brain syndrome 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Unknown cause DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) the physician attended the deceased from August 22, 1967 , to August 22, 1967 , that (I) we saw the deceased alive on August 19 63 , and that death occurred at 7:15 A , from the causes and on the date stated above.									
22a. SIGNATURE <i>W. T. Layman</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED August 24, 1967		
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.				22d. ADDRESS 100 Professional Arts Bldg, Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/25/1967		23c. NAME OF CEMETERY OR CREMATORY Harbaugh		23d. LOCATION (City, town or county) (State) Franklin Co. Washington Tws. Pa.			
24. FUNERAL DIRECTOR <i>Walter J. Grove</i>				ADDRESS Waynesboro, Pa		25a. REC'D BY REGISTRAR AUG 28 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

Washington	Maryland	Washington	Hagerstown	2 weeks	Hagerstown
			Hagerstown		Friendship Manor Nursing Home
07	August 22		Alexander	M.	Basile
	TO		10/21/1967	x	female wife
U.S.A.			Rousserville, Franklin Co. Va.		House wife
			Molly Shelton		Harry J. Martin
			216-01-6213 B Arthur M. Alexander Hagerstown, Md.		no

Unknown cause
 chronic brain syndrome
 atherosclerosis, cerebral & generalized with
 4 years

August 24, 1967	August 22, 67	August 22, 67	August 22, 67	August 22, 67	August 22, 67
100 Professional Arts Bldg, Hagerstown					
Franklin Co. Washington Ins.					
Waynesboro, Va. 22187					
8/25/1967					
Harbaugh					
William T. Latham, M.D.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

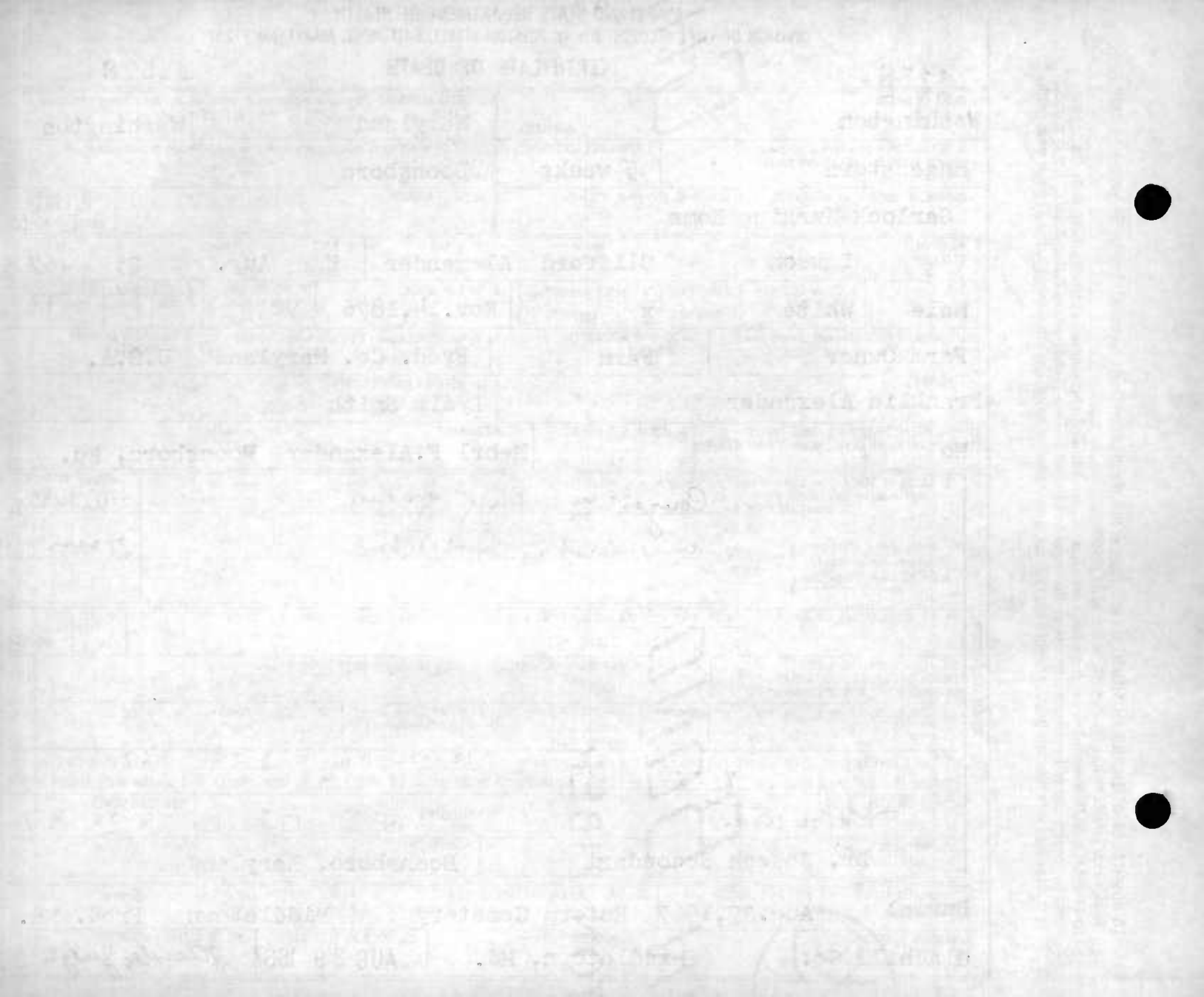
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawson Clifford Alexander		4. DATE OF DEATH Month Aug. Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1876
9. AGE (In years birthday) 90 yrs.		IF UNDER 1 YEAR Months 2 Days 1 Hours 1 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Fred. Co. Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Franklin Alexander		14. MOTHER'S MAIDEN NAME Lydia Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mehrl F. Alexander		Address Boonsboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 4200 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) arteriosclerotic heart disease DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 months 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-17- 19 60 , to 8-25- 19 67 , that (I) (we) last saw the deceased alive on 8-25- 19 67 , and that death occurred at 4 A M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph Secondari		22b. DATE SIGNED 8-26-67	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph Secondari		22d. ADDRESS Boonsboro, Maryland	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF Aug. 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Reform Cemetery		23d. LOCATION (City or Town) (County) (State) Middletown Fred. Md.	
24. FUNERAL DIRECTOR Gladhill Co.		25a. REC'D BY REGISTRAR DATE AUG 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Taylor Residence, Main Street		d. STREET ADDRESS RFD#2, Harpers Ferry, W. Va.	
3. NAME OF DECEASED (Type or print) DOSWELL CORRINNE BAGENT		4. DATE OF DEATH Month August Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1911
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 8 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Northumberland Co., Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd Morgan Lewis		14. MOTHER'S MAIDEN NAME Alice Corrinne Allison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 578-34-8139	
17. INFORMANT Clifford M. Taylor		Address RFD #2, Knoxville, Maryland 21758	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized abdominal DUE TO Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 1992		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Pulmonary Edema			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		22. DATE SIGNED 8/12/67	
EXAMINER'S NAME (Type) Edward W. Ditto III		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 8/14/67		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
23d. LOCATION (City or Town) (County) (State) Bolivar, West Va.		24. FUNERAL DIRECTOR Donald Eickles	
25a. REC'D BY REGISTRAR AUG 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

Washington Virginia London

January 10, 1900 I have Received

Letter of the Secretary of the

Board of Directors of the

Company and have

been very much

pleased to hear

of the success

of the work

done by the

committee and

trust that the

rest of the

year will be

very successful

and that the

company will be

able to carry

FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/67

11580

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Waynesboro, Penna.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Washington County Hospital		d. STREET ADDRESS R.D.1	
3. NAME OF DECEASED (Type or print) Bruce M. Bakner		4. DATE OF DEATH Month August Day 17 Year '67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/1899
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Group leader Chaser Dept. Landis Machine		10b. KIND OF BUSINESS OR INDUSTRY Co.	
11. BIRTHPLACE (State or foreign country) R.D.1 Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Bakner		14. MOTHER'S MAIDEN NAME Flora Etta Birley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 173-03-0836A	
17. INFORMANT Mrs. Bruce M. Bakner		Address R.D.1 Waynesboro, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Atherosclerotic Pneumonia of DUE TO Lower Abdominal Aorta, Ruptured (b) Diffuse Retroperitoneal Hematoma DUE TO 1-2hr (c) 1-2hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Beriberi, hepatic sclerosis - metastatic hyperostosis			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		22. DATE SIGNED 8/18/67	
EXAMINER'S NAME (Type) Edward W. Ditto 111, M.D.		Address (Street, city, town, or county) 217 W. Wash. Hagerstown, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/20/1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion	23d. LOCATION (City or Town) (County) (State) R.D.1 Waynesboro Franklin Pa.
24. FUNERAL DIRECTOR Nathan Z. Grove		25a. REC'D BY REGISTRAR DATE AUG 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		Address (Street, city, town, or county)	

Washington

James

Franklin

Washington

James

Washington, James

DCS Washington County Hospital

R.O.I.

August 17 07

Belmont

M.

Brice

x

white

male

11/27/1939 67

Group Leader Chamber Dept. Machine Co. R. I. Washington, Pa.

U.S.A.

Flore Jean Willey

Benjamin F. Baker

173-03-0330A Mrs. Brice M. Baker R.O.I. Washington, Pa.

no

Mr. Glen

11/27/1939

initial

R.O.I. Washington Franklin Co.

Washington, Pa.

AUG 1 1937

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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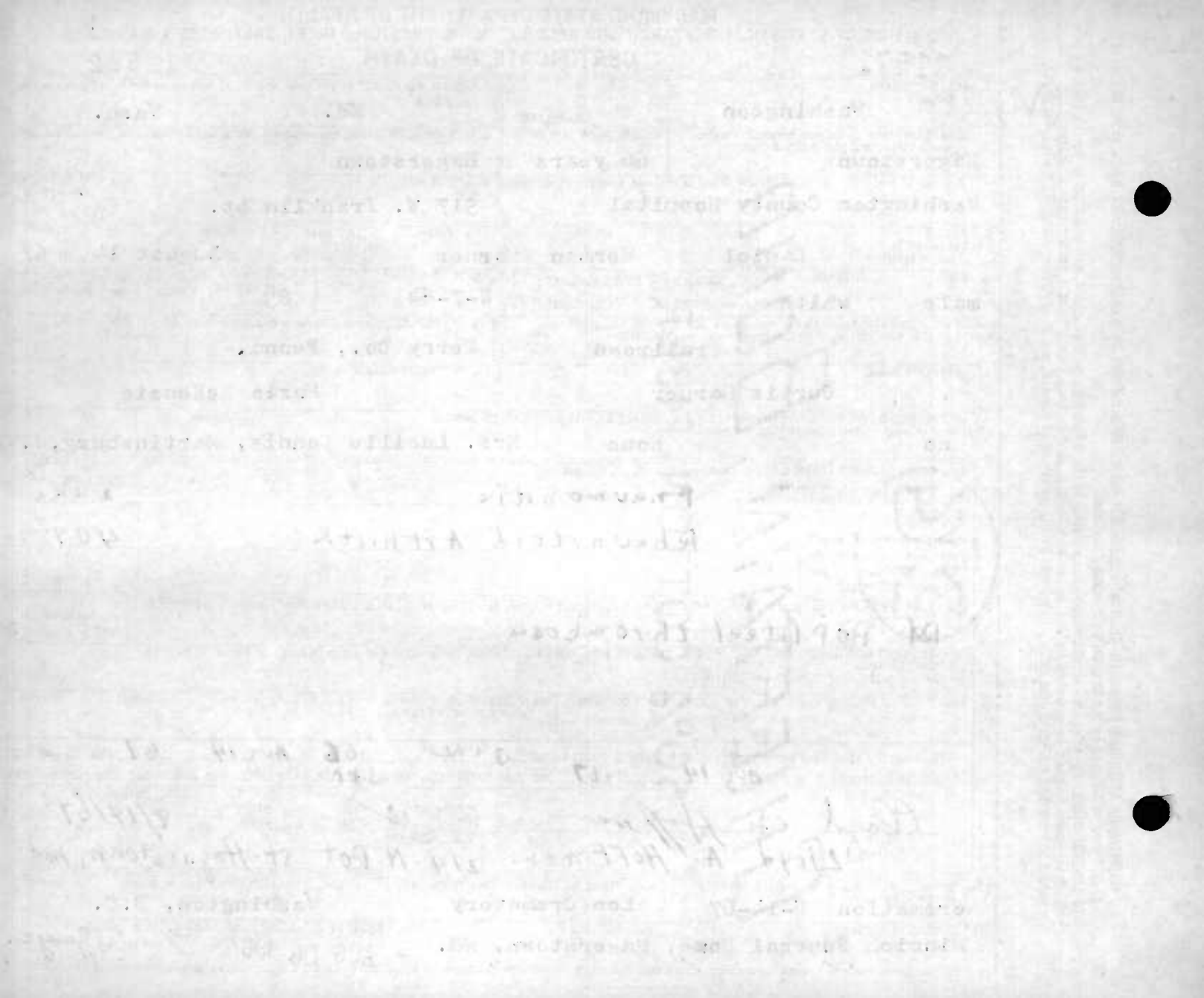
<div> <div>1</div> <div> <div>115-0</div> <div>Item #6 Film #G392 9/11/67</div> </div> <div> <div>11581</div> <div>211</div> </div> </div> <div> <div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div> </div>										<div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div>									
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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11571					11582						
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 66 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 917 W. Franklin St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daniel			First Herman		Middle Barner		Last Barner		4. DATE OF DEATH Month August Day 14 Year 1967		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-84		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 8 Days 3 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad				10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (County & State, or foreign country) Perry Co., Penna.			12. CITIZEN OF WHAT COUNTRY? Perry Co., Penna.		
13. FATHER'S NAME Curtis Barner					14. MOTHER'S MAIDEN NAME Maria McKenzie						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Lucille Dennis, Martinsburg, W.Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 7220 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Rheumatoid Arthritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Popliteal thrombosis										INTERVAL BETWEEN ONSET AND DEATH 2 wks 40 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to Aug 14 , 19 67 , that (I) (we) last saw the deceased alive on Aug. 14 , 19 67 , and that death occurred at 3:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE Clayton A. Hoffman										22b. DATE SIGNED 8/14/67	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman										22d. ADDRESS 214 N. Pot. St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 8-14-67		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory			23d. LOCATION (City, town or county) (State) Washington, D.C.				
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE AUG 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained in hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blue Ridge Summit d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blue Ridge Summit d. STREET ADDRESS Box 481 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WALTER Last BARNES		4. DATE OF DEATH Month AUG Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1905
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 14 Hours 19 Min.	IF UNDER 24 HRS. Months 62 Days 14 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Abraham Barnes	
14. MOTHER'S MAIDEN NAME Minnie Maun		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II	
16. SOCIAL SECURITY NO. 203-10-8354		17. INFORMANT Mrs. John Barnes, Box 481, Blue Ridge Summit, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 June 1967 to 14 Aug 1967 , that I last saw the deceased alive on 28 July 1967 , and that death occurred at 5:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Blue Ridge Summit, Penna. DATE SIGNED 8/14/67			
ACTUAL SIGNATURE Harry H. Youngs, Jr. M.D.			
PHYSICIAN'S NAME (Type) Harry H. Youngs, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/1967	22c. NAME OF CEMETERY OR CREMATORY Harbaugh's Cemetery
22d. LOCATION (City, town, or county) (State) Wash. Twp., Franklin Co., Pa.		22e. REC'D BY REGISTRAR Charles Judge	
23. FUNERAL DIRECTOR'S SIGNATURE P. Martin Poe		ADDRESS Waynesboro, Penna.	24b. REGISTRAR'S SIGNATURE Charles Judge

1268-21-809

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11573

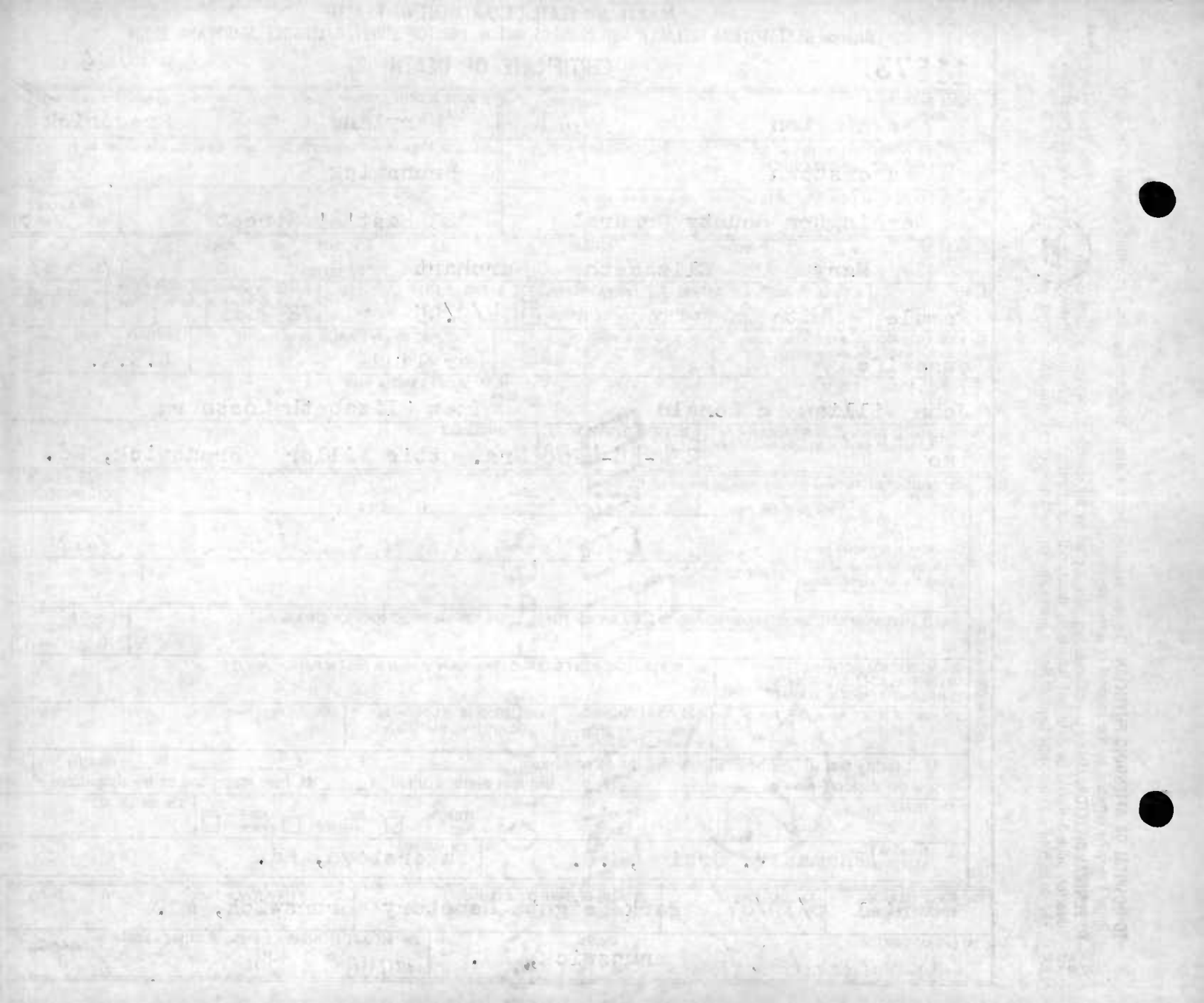
CERTIFICATE OF DEATH

11584

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County General		d. STREET ADDRESS 23 East 'B' Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Barnhart		4. DATE OF DEATH Month 8 Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/95
9. AGE (In years lost birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Mc Donald		14. MOTHER'S MAIDEN NAME Inez Elizabeth Mossburg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-48-4168	
17. INFORMANT Mrs. Ottie Miller		Address Brunswick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the colon DUE TO (b) Diffuse liver metastases DUE TO (c) 1967			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes on and on the date stated above.			
22a. SIGNATURE Thomas V. Craig		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas V. Craig, M.D.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Type)	23b. DATE THEREOF 8/19/67	23c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery	23d. LOCATION (City or town) (County) (State) Brunswick, Md.
24. FUNERAL DIRECTOR Fete Funeral Home		ADDRESS Brunswick, Md.	
25a. REC'D BY REGISTRAR DATE AUG 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



11585

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11574

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 312 NORTH MULBERRY STREET			d. STREET ADDRESS 312 NORTH MULBERRY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ERNEST RAGAN BARR			4. DATE OF DEATH Month AUGUST Day 20 Year 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 20, 1908	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months 20 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY PAINTING CONTRACTOR.		11. BIRTHPLACE (State or foreign country) HAGERSTOWN, MARYLAND.	
13. FATHER'S NAME CLARENCE ALFRED BARR			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-09-0626		
17. INFORMANT MRS. EVELYN D. BARR, HAGERSTOWN, MARYLAND.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of gastric Contents DUE TO Alcoholic Intoxication (b) (Chronic Alcoholic) DUE TO (Chronic Alcoholic) (c) (Chronic Alcoholic)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 6-30 Hrs 7 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) asth. tuberculosis - Active & Extensive					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward W. Ditto, III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) EDWARD W. DITTO, III M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/23/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR AUG 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
23d. LOCATION (City or Town) HAGERSTOWN, WASH. CO. MD.		23e. (County) (State)			

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CERTIFICATE OF DEATH

11586

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 yrs ?</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Lee Barrett</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2, 1909</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Winchester, Vt.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Grace Kandle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-22-7101</u>	
17. INFORMANT Address <u>Wash. Co. welfare off. Hagerstown, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Latent Cues: Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15, 1962</u> , to <u>Aug 23, 1962</u> , that (I) (we) last saw the deceased alive on <u>Aug 23, 1962</u> , and that death occurred at <u>1:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. D. 11/10-III</u>		22b. DATE SIGNED <u>8/24/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cath. Md. Med. School</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md</u>
24. FUNERAL DIRECTOR <u>Minnie's Funeral Home Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>AUG 28 1967</u>	

CERTIFICATE OF DEATH

11576

11587

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 5 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 317 W Patrick St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AMANDA BEAL BAUGHER				4. DATE OF DEATH Month 8 Day 18 Year 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-01	9. AGE (In years last birthday) yrs. 66	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM BEAL				14. MOTHER'S MAIDEN NAME anna Renner.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-24-8025		17. INFORMANT Charles W. Baugher Address Frederick, Md. RD 7			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinomatosis DUE TO Carcinoma of Left Maxillary antrum CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) 16 years. (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that HE (this hospital) attended the deceased from 3-10 , 19 67 , to 8-18 , 19 67 , that HE (we) last saw the deceased alive on 8-18 , 19 67 , and that death occurred at 4:20 M, from causes and on the date stated above.							
22a. SIGNATURE NEVARDO LAYZECQUILLA				22b. DATE SIGNED 8-18-67		22c. PHYSICIAN'S NAME (Type) NEVARDO LAYZECQUILLA	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-20-67		23c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		23d. LOCATION (City or Town) (County) (State) Lewistown Fred. Co. Md.	
24. FUNERAL DIRECTOR Raymond E. Creager				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. ADDRESS Thurmont, Md.				DATE AUG 21 1967			

CERTIFICATE OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11588

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 354 So Locust St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DOROTHY ELIZABETH BEICHLER		4. DATE OF DEATH Month August Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 3 1930
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine		10b. KIND OF BUSINESS OR INDUSTRY Dress Factory	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ray Griffith		14. MOTHER'S MAIDEN NAME Mabel Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-24-1514	
17. INFORMANT Mrs Mabel Holmes Keedysville Md		Address Box 37	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Calcific Aortic And Mitral Valvulopathy: Severe DUE TO Stenosis (Probable Old Rheumatic Disease) (b) Auricular Thrombi, Left, Recent And Fresh DUE TO Right Ventricular And Auricular Dilation And (c) Hypertrophy, Severe		INTERVAL BETWEEN ONSET AND DEATH Several years Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE A. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 8-29-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/1/67	
23c. NAME OF CEMETERY OR CREMATORY Mt View Cemetery		23d. LOCATION (City or Town) (County) (State) sharpsburg Wash Co Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR SEP 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15ME (5)
6M 1/66

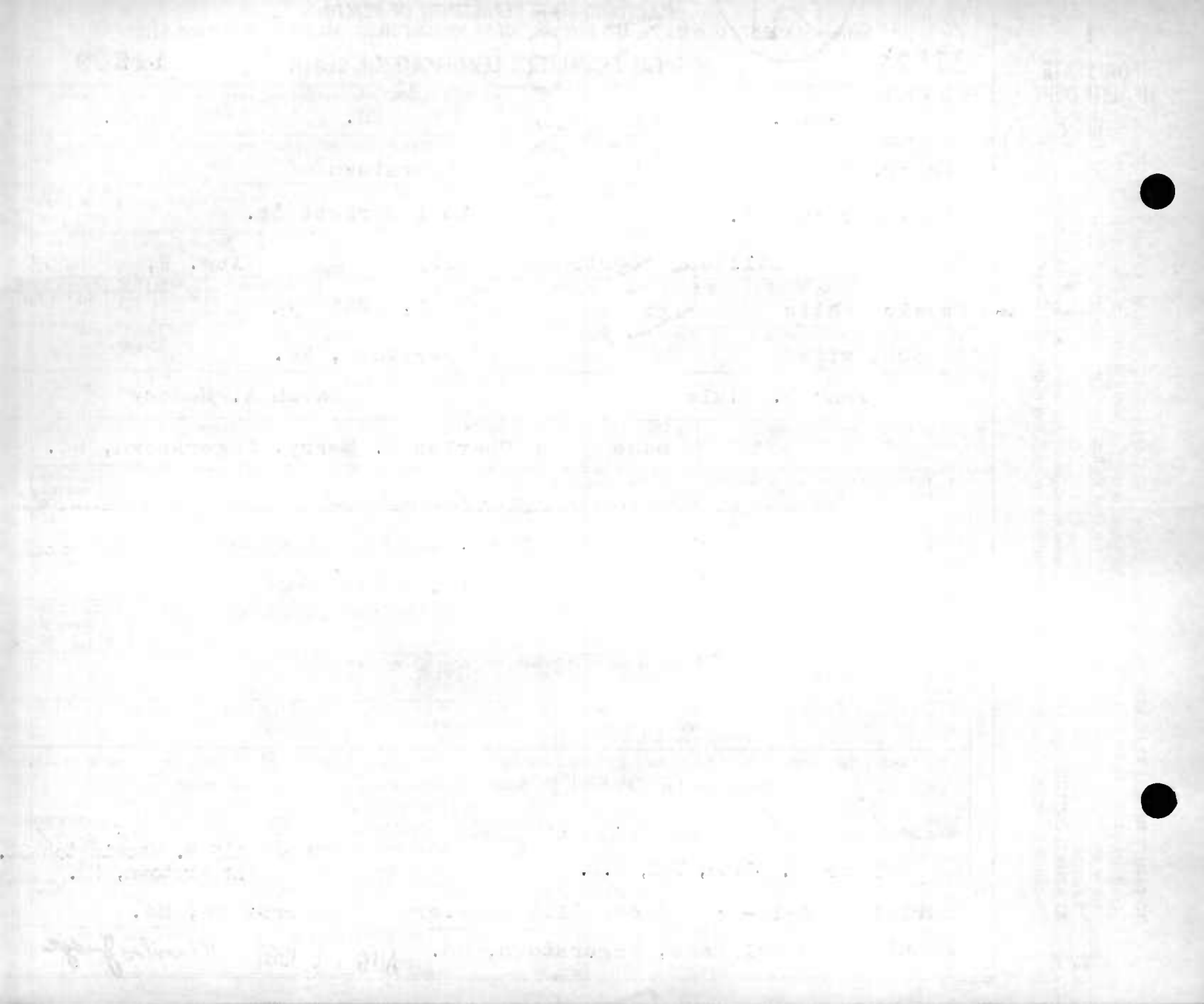
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11589

1. PLACE OF DEATH a. COUNTY Wash. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 1001 Corbett St.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1001 Corbett St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Gertrude Last Berry		4. DATE OF DEATH Month Aug. Day 7 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1891 9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank S. Bikle		14. MOTHER'S MAIDEN NAME Sarah A. Munday	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles R. Berry, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion - DUE TO Arteriosclerotic heart disease (b) + general arteriosclerosis DUE TO Arteriosclerotic heart disease (c) + general arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 217 W. Washington St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-10-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR AUG 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



11573

CERTIFICATE OF DEATH

11591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS 132 North Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMORY Middle LUTHER Last BITTLE				4. DATE OF DEATH Month August Day 2 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1881	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 2 Days 19 Hours 67 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison		11. BIRTHPLACE (County & State, or foreign country) Myersville, Fred. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Metzger Bittle				14. MOTHER'S MAIDEN NAME Catherine Routzahn Floyd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT 132 North Ave., Hagerstown, Md. Mrs. Elizabeth Brandenburg.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis - left hemisphere DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 10 days years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 July , 19 67 , to 2 Aug , 19 67 , that (I) (we) last saw the deceased alive on 2 Aug 1967 , and that death occurred at 7A M, from causes and on the date stated above.							
22a. SIGNATURE R. T. Binford				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4 August 67	
22c. PHYSICIAN'S NAME (Type) R. T. Binford, M. D.				22d. ADDRESS 1135 Potomac Avenue Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 5, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran		23d. LOCATION (City or Town) (County) (State) Myersville, Md. Co. Md.	
24. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md.				25a. REC'D BY REGISTRAR AUG 7 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

100

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

WASHINGTON, D. C. 20315

OFFICE OF THE DIRECTOR OF THE BUREAU OF THE ARMY

WASHINGTON, D. C. 20315

OFFICE OF THE DIRECTOR OF THE BUREAU OF THE ARMY

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OFFICE OF THE DIRECTOR OF THE BUREAU OF THE ARMY

WASHINGTON, D. C. 20315

OFFICE OF THE DIRECTOR OF THE BUREAU OF THE ARMY

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-62)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11592											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b. 2 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clear View Nursing Home						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg d. STREET ADDRESS RD 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Minnie V. Bowman						4. DATE OF DEATH Month Day Year Aug. 3rd 1967					
5. SEX F		6. COLOR OR RACE Cau.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1884		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife				10b. KIND OF BUSINESS OR INDUSTRY home				11. BIRTHPLACE (County & State, or foreign country) Garfield Frederick Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Hanson Draper						14. MOTHER'S MAIDEN NAME Mary J. Weddle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 215-18-2380		17. INFORMANT Cleg A. Bowman, Smithsburg RD1, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Esophageal Stricture & Arteriosclerotic Heart Disease & Dehydration 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 5/3/1967 to present , 19 67 , that (I) (we) last saw the deceased alive on Aug. 3, 1967 , and that death occurred at 9:55 PM , from the causes and on the date stated above. 22a. SIGNATURE William O. Rexrode M.D. 22c. PHYSICIAN'S NAME (Type) Dr. William O. Rexrode 22b. DATE SIGNED 145 S. Prospect St. Hagerstown, Maryland 23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF Aug. 6, 1967 23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery 23d. LOCATION (City, town or county) (State) Smithsburg, Wash., Md. 24. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home, Smithsburg, Md. 25a. REC'D BY REGISTRAR AUG 7 1967 25b. REGISTRAR'S SIGNATURE Charles Judge											

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1907
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1906
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1907



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (1)
6M 1/66

Items 18&21 Film 392

9-11-67

MARYLAND STATE DEPARTMENT OF HEALTH

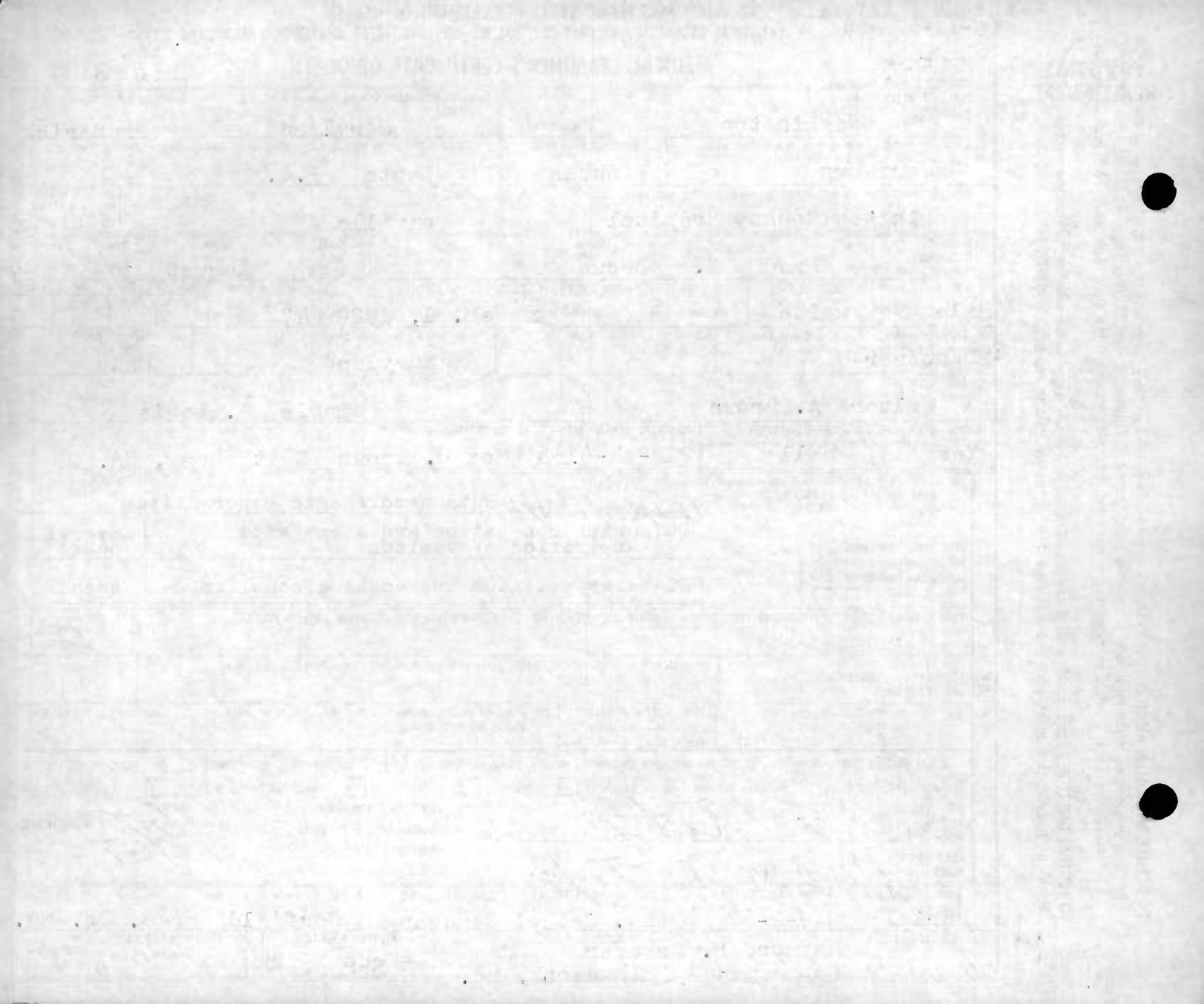
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11593

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz P.O.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS Foxville	
3. NAME OF DECEASED (Type or print) First Fred Middle M. Last Brown		4. DATE OF DEATH Month August Day 30 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1920
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter A. Brown		14. MOTHER'S MAIDEN NAME Minnie G. Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 212-14-6166	
17. INFORMANT Max H. Brown		Address Smithsburg, Md. RD 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis DUE TO (b) Pulmonary congestion and edema with aspiration of vomitus DUE TO (c) Diabetes mellitus and acute alcoholism			INTERVAL BETWEEN ONSET AND DEATH Several hours Recent
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature] M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Dittus		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-2-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery	23d. LOCATION (City or Town) (County) (State) Garfield Fred. Co. Md.
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR SEP 5 1967	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11582

11584

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown R # 6</u>		d. STREET ADDRESS <u>Route # 6</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Newcomer</u> Last <u>Brumbaugh</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1875</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rural Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Nicholas Brumbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth J. Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-38-084</u>	
17. INFORMANT <u>Miss Helen Brumbaugh</u>		Address <u>Arlington, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4700 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Permeable Cerebrum</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m." <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>67</u> , to <u>8-28</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8-28</u> 19 <u>67</u> , and that death occurred at <u>9:30 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>8-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCISCO E. ROSILLO</u>		22d. ADDRESS <u>580 Northern Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	
ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CONFIDENTIAL

Washington County Hospital
Department of Health
Washington County, Oregon
1970

1970
100-32,1872
PT

Washington County Hospital
Department of Health
Washington County, Oregon

218-38-081
A

Washington County Hospital
Department of Health
Washington County, Oregon
1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>106 S. Church St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mary Ellen Bussard</u>			4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Dec. 20, 1912</u>			9. AGE (In years last birthday) <u>54</u> yrs.			10. IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u> Hours <u>Min.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Washington, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Harvey Crampton</u>					
14. MOTHER'S MAIDEN NAME <u>Grace Boyer</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>None</u>						17. INFORMANT <u>James Bussard</u> Address <u>106 S. Church St. Sharpsburg, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of (L) Breast with Metastases</u> DUE TO (b) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Advanced arthritis of the spine</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>5/16/66</u> , 19 <u>66</u> , to <u>Aug 23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 22</u> , 19 <u>67</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>8/23/67</u>				22c. PHYSICIAN'S NAME (Type) <u>R. AMARILLO</u>			
22d. ADDRESS <u>Sharpsburg, Md</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Aug. 26, '67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Sharpsburg, Wash. Maryland</u>				24. FUNERAL DIRECTOR <u>Albert L. Leaf</u> <u>7 Church St. Williamsport, Maryland</u>							
25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

UNITED STATES OF AMERICA

Washington, D.C.

Department of State

Office of the Secretary

Room 5638

Washington, D.C.

August 2, 1967

Dear Mr. Secretary:

I am pleased to hear

from you and hope

you are well.

I am sure you will

find this letter

of interest.

I am sure you will

find this letter

of interest.

I am sure you will

find this letter

AUG 2 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11584

11596

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS ROUTE # 1	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle HATTIE Last CARTER		4. DATE OF DEATH Month AUGUST Day 10 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH SEPT. 19, 1903
9. AGE (In years and months) 63 yrs.		IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	
11. BIRTHPLACE (County & State, or foreign country) TILGHMANTON, WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD LEE DAVIS		14. MOTHER'S MAIDEN NAME JULIA LAVINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 220-09-7301	
17. INFORMANT MRS. KENNETH KLINE, ROUTE # 1, BOONSBORO, MARYLAND.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure - arrhythmias DUE TO (b) acute myocardial infarction DUE TO (c) arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 18 hours two days not determined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial thrombosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 Aug , 19 67 , to death , 19 67 , that (I) (we) last saw the deceased alive on 7 Aug , 19 67 , and that death occurred at 9:15 AM , from causes and on the date stated above.			
22a. SIGNATURE John C. Stauffer		22b. DATE SIGNED AUGUST 11, 1967	
22c. PHYSICIAN'S NAME (Type) JOHN C. STAUFFER, M.D.		22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/12/67	
23c. NAME OF CEMETERY OR CREMATORY MANOR CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) TILGHMANTON, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DATE AUG 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11585					11597					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			c. LENGTH OF STAY IN 1b <u>8 mos. 10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u>			d. STREET ADDRESS <u>410 Eulalia St.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertrude S. Chambers</u>					4. DATE OF DEATH Month Day Year <u>August 20 1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 5, 1887</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>79</u> yrs. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Washington County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Christian Snyder</u>					14. MOTHER'S MAIDEN NAME <u>Mary Jane Watson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Charles E Chambers</u> Address <u>1105 Circle Drive Martinsburg, W. Va. 25401</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u> <u>10 yrs 3</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19, 1966</u> , to <u>Aug 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 14, 1967</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>M. E. Byrkit</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 20-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>					22d. ADDRESS <u>Williamsport Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-23-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Martinsburg, West Va.</u>			
24. FUNERAL DIRECTOR <u>H. N. Brown</u> <u>Brown Funeral Home</u>					ADDRESS <u>Martinsburg, W. Va.</u>		25a. REC'D BY REGISTRAR <u>AUG 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Memorandum

TO : DIRECTOR, FBI

x

FROM : SAC, WASHINGTON FIELD (100-33401)

DATE: 10/1/67

SUBJECT: [Illegible]

RE: [Illegible]

NO

WASHINGTON, D. C. 20535

100-33401

10/1/67

100-33401

WASHINGTON, D. C. 20535

100-33401

11586

CERTIFICATE OF DEATH

11588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		217	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 2377 Pennsylvania Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Leroy Chaney				4. DATE OF DEATH Month 8 Day 13 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-02	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector Railroad		10b. KIND OF BUSINESS OR INDUSTRY Rail road		11. BIRTHPLACE (County & State, or foreign country) Washington Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Chaney				14. MOTHER'S MAIDEN NAME Bertha Chaney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ****		16. SOCIAL SECURITY NO. 705-10-5527		17. INFORMANT MRS. HELEN L. CHANEY, 2377 PENNSYLVANIA AVE. HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinomatosis 154X DUE TO (b) carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-13, 1967 , to 8-13, 1967 , that (I) (we) last saw the deceased alive on 8-13, 1967 , and that death occurred at 6:30 PM , from causes and on the date stated above.							
22a. SIGNATURE NEVARDO LAYZECUILLA				22b. DATE SIGNED 8-13-67		22c. PHYSICIAN'S NAME (Type) NEVARDO LAYZECUILLA	
22d. ADDRESS 1500 Pennsylvania Ave.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/16/67		23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY.		23d. LOCATION (City or Town) (County) (State) WILLIAMSPORT, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR DATE AUG 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

CERTIFICATE OF DEATH

State of Washington
County of King
City of Seattle
I, the undersigned, being a duly qualified physician, do hereby certify that
the within and foregoing is a true and correct copy of the original
certificate of death filed in my office on the 1st day of January, 1911.
Attest my hand and seal of office this 1st day of January, 1911.
J. H. [Signature]
Physician

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11587					11599				
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.				
b. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 35 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 351 S. Cannon Ave.			e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Betty Middle Lorraine Last Churchey			4. DATE OF DEATH Month August Day 26, Year 1967						
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-25-30		9. AGE (in years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY dress mfg.		11. BIRTHPLACE (County & State, or foreign country) Wash. Co., Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Clarence Forsyth				14. MOTHER'S MAIDEN NAME Margaret Palmer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 215-26-2094		17. INFORMANT Charles Churchey, Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 REPERFUSION EPISODES CARDIAC ARREST DUE TO CONGESTIVE HEART FAILURE (b) PNEUMONITIS AND TO DUE TO EXTENSIVE ROTOSCOLIOSIS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASPIRATION OF VOMITUS INTO TRACHEOBRONCHIAL TREE								INTERVAL BETWEEN ONSET AND DEATH 2 1/2 HOURS 5 DAYS 5 DAYS 36 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from AUG 21, 1967 to AUG 26, 1967, that (I) saw the deceased alive on AUG 26, 1967, and that death occurred at 2:45 PM, from the causes and on the date stated above.									
22a. SIGNATURE W. T. Layman, M.D.					22b. DATE SIGNED AUG 28, 1967			22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 8-29-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.					25a. REC'D BY REGISTRAR AUG 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

1200425
1200422
1200421
1200420

1. General
 2. Particular
 3. Conclusion
 4. Summary
 5. Remarks
 6. Signature
 7. Date
 8. Place
 9. Page
 10. Total

PLACEMENT OF U.S. AIR FORCE IN THE

[Faint handwritten notes at the bottom of the page, possibly bleed-through from the reverse side.]

W. G. T. Adams, Jr.
1892

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD 4					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown d. STREET ADDRESS RFD 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Mabel Middle Littleton Last Clark					4. DATE OF DEATH Month August Day 5 Year 1967				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-1899		9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Indian Springs, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Holland					14. MOTHER'S MAIDEN NAME McAllister				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Betty Munson, Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery dis. DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension; Depression									INTERVAL BETWEEN ONSET AND DEATH 1 day Several yrs. yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7 Feb 1967 to 2 Aug 1967 , that (I) (we) last saw the deceased alive on 2 Aug 1967 , and that death occurred at 6 AM , from the causes and on the date stated above.									
22a. SIGNATURE Richard T. Binford					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.		
22d. ADDRESS 1135 Potomac Avenue Hagerstown, Maryland					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8-8-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.					25a. REC'D BY REGISTRAR AUG 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

DECLARATION OF DEPENDENCY

Washington
Tami Anderson
20 years
1971-1991
1971-1991

Annual
1991-1992
1-2-1992

Indian Springs, W. Va.
Charles Holland
Washington

from, every person, dependent, and

[Faint, illegible handwritten text]

1991-1992
1991-1992
1991-1992

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11589

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11601

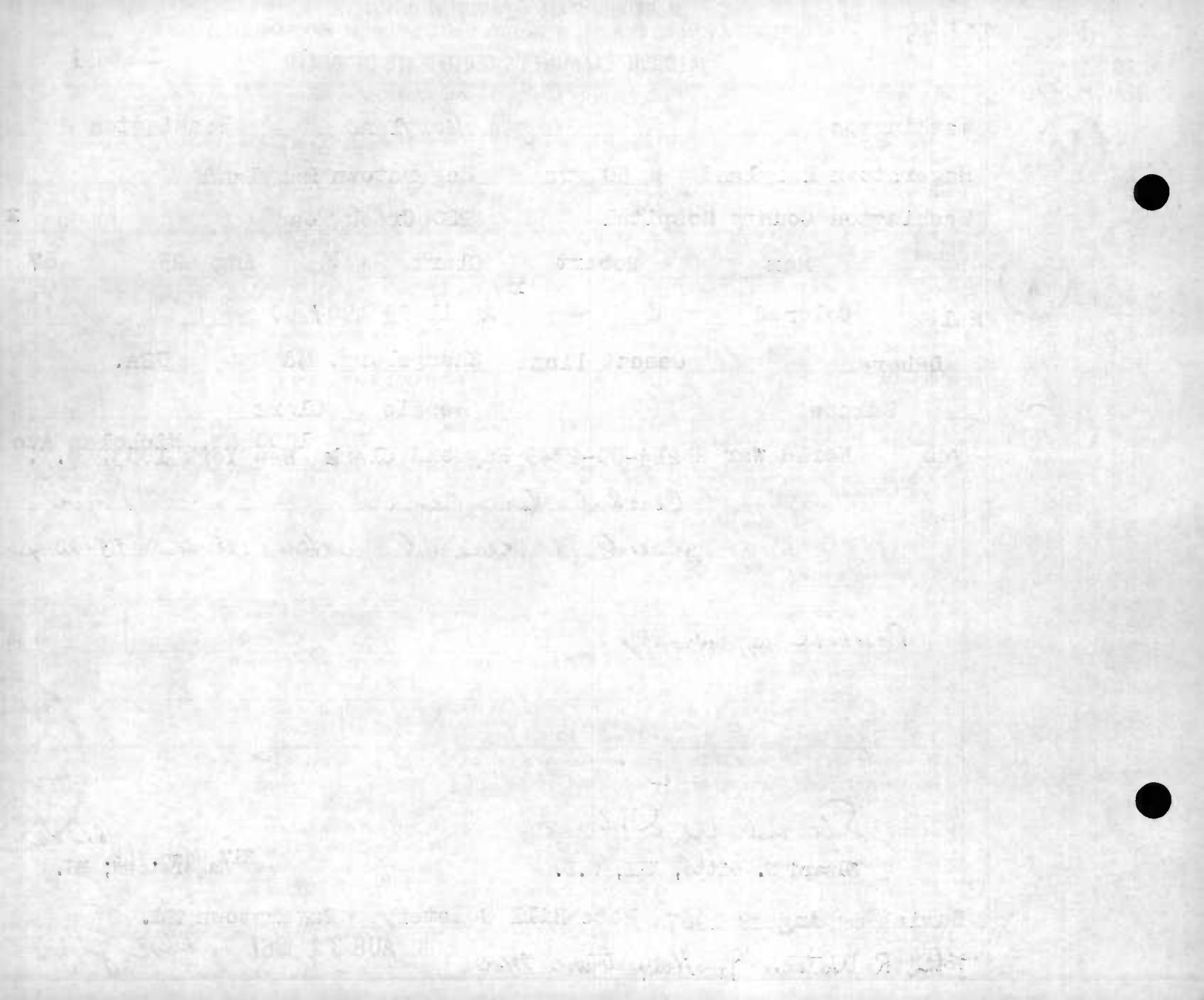
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland c. LENGTH OF STAY IN 1b 50 yrs			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland d. STREET ADDRESS 220 Creek Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Max Robert Clark			4. DATE OF DEATH Month Day Year Aug 25 1967		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29 1907 60		9. AGE (In years last birthday) yrs. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cement Plant	11. BIRTHPLACE (State or foreign country) Sharpsburg, Md		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Bessie Clark		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes World War 2		16. SOCIAL SECURITY NO. 214-09-2349	17. INFORMANT Raymond Clark Address 1000 St Nicholas Ave New York 10032 N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332 X IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) general + cerebral arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 yr 15-20 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostate hypertrophy					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward W. Ditto III		M.D. Edward W. Ditto, III, M.D.		22. DATE SIGNED 8/28/67	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		Address (Street, city, town, or county) 217 Wash. St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 29 1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Md.		
24. FUNERAL DIRECTOR John R Watson Jr		ADDRESS Hagerstown Md		25a. REC'D BY REGISTRAR DATE AUG 31 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

79

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

11590

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11602

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 36 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 1030 Kuhn Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last CONLEY		4. DATE OF DEATH Month August Day 10 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-27
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner		10b. KIND OF BUSINESS OR INDUSTRY confectionary sto	
11. BIRTHPLACE (County & State, or foreign country) Washington township, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry M. Sixeas		14. MOTHER'S MAIDEN NAME Susan Benchoff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-18-1894	
17. INFORMANT Willard Conley, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7571 sepsis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) polycystic kidneys DUE TO (c) liver		INTERVAL BETWEEN ONSET AND DEATH weeks lifelong	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) polycystic liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to death , 19____, that (I) (we) last saw the deceased alive on 9 Aug 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John C. Stauffer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-12-67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 14 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

11591

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 10401 Grosvnor Place	
3. NAME OF DECEASED (Type or print) First Sallie Middle Elizabeth Last Cornwall		4. DATE OF DEATH Month August Day 11 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 24, 1889
9. AGE (In years last birthday) yrs. 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) housewife	
11. BIRTHPLACE (County & State, or foreign country) RELIANCE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES L. SARGEANT		14. MOTHER'S MAIDEN NAME CATHERINE DERFLINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		16. SOCIAL SECURITY NO. 578-20-5978A	
17. INFORMANT MRS. ALMA PIPER,		Address 10401 GROSVNOR PLACE, ROCKVILLE, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease - fibrillation DUE TO (b) acute coronary thrombosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 year 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrene left leg upper upper thigh amputation left 8-11-67			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-10- , 19 67 , to 8-11- , 19 67 , that (I) (we) last saw the deceased alive on 8-11- , 19 67 , and that death occurred at 9:33 P.M. , from causes and on the date stated above.			
22a. SIGNATURE J. H. Kehue M.D.		22b. DATE SIGNED AUGUST 12, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. J. H. Kehue		22d. ADDRESS 1229 Ravenwood Heights, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-14-67	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Mt Kainer Prince Geo Md
24. FUNERAL DIRECTOR Robert A Pumphrey 7557 Wisconsin Ave		25a. REC'D BY REGISTRAR Bethesda, Md	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 21 1967	

STATE OF TEXAS

IN SENATE,
January 11, 1901.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.
BY
J. W. HARRIS,
COMMISSIONER.

ALBUQUERQUE, N. M.,
JANUARY 11, 1901.
TO THE
SENATE.

J. W. Harris

PRINTED BY
THE
GOVERNMENT
PRINTING
OFFICE,
WASHINGTON,
D. C.,
1901.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (5)
6M 1/67

11592		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		11604	
1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosemont			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Thomas Dawson				4. DATE OF DEATH Month 8 Day 20 Year 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/16/56	
9. AGE (In years lost birthday) yrs. 11		IF UNDER 1 YEAR Months 10 Days 2		IF UNDER 24 HRS. Hours 10 Min. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman L. Dawson				14. MOTHER'S MAIDEN NAME Ella Mae Virts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Norman L. Dawson Rosemont			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of gastric Contents - Rx 8134 DUE TO Result Cranial cerebral trauma - Loc. (b) Lt. frontal lobe - fr. into Lt. orbit DUE TO Subarachnoid hemorrhage - fr. Lt. Femur (c) pelvis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pelvis				INTERVAL BETWEEN ONSET AND DEATH 1-2 hr 13 hr			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by Auto while Riding Bicycle					
20c. TIME OF INJURY Month, Day, Year Hour am 12:30 p.m. 8/19/19 67		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Nr. Brunswick Fred Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto III, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 217 W. Wash. St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/67		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Petersville Md.	
24. FUNERAL DIRECTOR Freda General Home				25a. REC'D BY REGISTRAR DATE AUG 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>11593</div> <div>11605</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>828 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1 d. STREET ADDRESS <u>906 Marion Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Irving</u> Last <u>DeGrange</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1967</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 4, 1953</u>			9. AGE (In years, last birthday) <u>13</u> yrs. IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles DeGrange</u>					14. MOTHER'S MAIDEN NAME <u>Theda E. Sours</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-48-6861</u>		17. INFORMANT <u>Mr. & Mrs. C. J. DeGrange</u> Address <u>906 Marion St. Hagerstown Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho pneumonia</u> DUE TO <u>Secondary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>to Massive Brain Stem injury</u> DUE TO (c) <u>with Decerebration</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell From bicycle, Striking Back of Head</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7/25/1963</u> p.m. <u>7/25/1963</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Hagerstown Wash Md</u> (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Edward W. Dittus III</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>E. W. Dittus III, M.D.</u>					22. DATE SIGNED <u>8/6/67</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown - Washington - Md.</u>		
24. FUNERAL DIRECTOR <u>Wm. C. Hays</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>					25a. REC'D BY REGISTRAR <u>AUG 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

11594

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>Rural Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>R # 3</u>	
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Grant</u> Last <u>DeLanter</u>		4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1875</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ellerton, Fred. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David H. Delanter</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Louise Hoover</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-34-3430</u>	
17. INFORMANT <u>Guy D. Delanter R # 3 Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>10 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Upper Gastro-intestinal Hemorrhage</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>60</u> , to <u>8-22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8-29</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>9-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Hagerstown, Md.</u>	

Know all men by these presents, that W. C. Hunt of the County of Dallas State of Texas for and in consideration of the sum of Five Hundred and no/100 Dollars to him in hand paid by John W. Hunt the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said John W. Hunt all that certain Tract of Land situated in the County of Dallas State of Texas and more particularly described as follows, to-wit:

Tract of Land situated in the County of Dallas State of Texas and more particularly described as follows, to-wit:

Tract of Land situated in the County of Dallas State of Texas and more particularly described as follows, to-wit:

Witness my hand and seal of office this 10th day of April A.D. 1925 at the City of Dallas State of Texas.

W. C. Hunt
County Clerk

John W. Hunt
Buyer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11595

CERTIFICATE OF DEATH

11607

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>50 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>701 S. Potomac St.</u>				d. STREET ADDRESS <u>701 S. Potomac St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Franklin</u> Last <u>Dowler</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1897</u>		9. AGE (In years last birthday) yrs. <u>70</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deliveryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mdse. & Groceries</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bedford, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey E. Dowler</u>				14. MOTHER'S MAIDEN NAME <u>Cora M. Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-09-7559</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Edith Dowler 701 S. Potomac St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerosis heart given</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>67</u> , to <u>8/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/28</u> , 19 <u>67</u> , and that death occurred at <u>5:20 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Eldon S. Hoachlander</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8/8/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Eldon S. Hoachlander</u>				22d. ADDRESS <u>Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md</u>			
24. FUNERAL DIRECTOR <u>Wm. C. Host</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

11596

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>54 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jackson Convalescent Home</u>				d. STREET ADDRESS <u>25 1/2 N. Mulberry St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Lydia</u> Last <u>Ebersole</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1898</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Organ Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Peter Wedding</u>				14. MOTHER'S MAIDEN NAME <u>Fannie (Last name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-3640</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Elizabeth Houpt 25 1/2 N. Mulberry St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 443X DUE TO (b) <u>(Corteriosclerotic)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Indef.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 10, 1967</u> , 19 <u>67</u> , to <u>Aug 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 10, 1967</u> , and that death occurred at <u>11:45 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Kneisley</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>B. B. KNEISLEY</u>				22d. ADDRESS <u>148 W. Wash. St. Hagerstown W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown - Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>W. C. Hunt</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

REPORT OF DEATH

1176

Decedent's Name	John Doe
Sex	Male
Age	75
Marital Status	Married
Spouse's Name	Jane Doe
Place of Birth	London, England
Date of Birth	Jan 15, 1900
Place of Death	London, England
Date of Death	Aug 10, 1975
Cause of Death	Heart Disease
Physician's Name	Dr. Smith
Physician's Address	123 Main St, London
Physician's Phone	01-1234567
Funeral Home	Funeral Home Ltd.
Funeral Home Address	456 High St, London
Funeral Home Phone	01-7654321
Interment Place	St. Paul's Church
Interment Date	Aug 15, 1975
Interment Time	11:00 AM
Interment Address	St. Paul's Church, London
Interment Phone	01-9876543

Witness Signature: *W. C. Smith*
Witness Name: W. C. Smith
Witness Address: 123 Main St, London
Witness Phone: 01-1234567
Date: AUG 11 1975
Registrar Signature: _____
Registrar Name: _____
Registrar Address: _____
Registrar Phone: _____
Date: _____

11597

CERTIFICATE OF DEATH

11609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 15 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARLOCK CONVALESCENT HOME				d. STREET ADDRESS 318 BUENA VISTA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY EDITH ELLIOTT		4. DATE OF DEATH Month AUGUST Day 11 Year 1967		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 16, 1875		9. AGE (In years last birthday) yrs. 91		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) GREEN SPRING, W. VIRGINIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DARR				14. MOTHER'S MAIDEN NAME FRANCES (UNKNOWN)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MR. DUDLEY CRABTREE, HOLLYWOOD, CALIFORNIA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED.						INTERVAL BETWEEN ONSET AND DEATH 2 mos. Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 11 MAY , 1967, to 11 AUGUST , 1967, that (I) (we) last saw the deceased alive on 3 AUGUST 1967, and that death occurred at 5:30 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>William Noel Fender</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 14 AUGUST 1967	
22c. PHYSICIAN'S NAME (Type) WILLIAM NOEL FENDER, M.D.				22d. ADDRESS 218 N. POTOMAC ST. HAGERSTOWN, MARYLAND.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/17/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR DATE AUG 18 1967		25b. REGISTRAR'S SIGNATURE <i>Charles M. Rouzer</i>	

STATE OF TEXAS

COUNTY OF DALLAS

WARRANT

IN CRIMINAL CASE NO. 12345

THE STATE OF TEXAS

VS.

JAMES EARL RAY

ALIAS

ET AL.

ET AL.

ARRESTED

ON

THIS

DAY

OF

THE

MONTH OF

1968

AT

DALLAS, TEXAS

BY

THE

CLERK OF THE DISTRICT COURT

IN AND FOR THE COUNTY OF DALLAS

STATE OF TEXAS

VS.

JAMES EARL RAY

ALIAS

ET AL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

90

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
11598					CERTIFICATE OF DEATH					11610				
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 101 East Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) SUSAN ELIZABETH EVANS			First		Middle		Last		4. DATE OF DEATH August 26 1967 Month Day Year					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jany 17 1894		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Hag Shoe Co		11. BIRTHPLACE (County & State, or foreign country) Everton Harford Co Md			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Edward Evans					14. MOTHER'S MAIDEN NAME Joanna Wakeling									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 230-10-3368		17. INFORMANT Jack Evans Address 941 D Lamvale St										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Arteriosclerotic Cardiac DE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 42 21										INTERVAL BETWEEN ONSET AND DEATH 1 day				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. INCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 18 May 1967 to 12 July 1967 , that (I) (we) lost saw the deceased alive on 12 July 1967 , and that death occurred at 2360 M, from causes and on the date stated above.														
22a. SIGNATURE Richard T. Binford				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 28 August 1967								
22c. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.				22d. ADDRESS 1135 Potomac Avenue Hagerstown, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/30/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md							
24. FUNERAL DIRECTOR Hagerstown Md				25a. REC'D BY REGISTRAR Andrew K. Coffman		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 5 1967						

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M

79

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
11599					CERTIFICATE OF DEATH					11611					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>					10-7					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hostital</u>					d. STREET ADDRESS <u>III Fourth Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES HARRY EVERITTS</u>					4. DATE OF DEATH Month Day Year <u>8 4 19 67</u>										
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/14/1892</u>		9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired B&O R.R. employee</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>Amos Everitts</u>					14. MOTHER'S MAIDEN NAME <u>Ida Mae Armstrong</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>705-09-7691</u>			17. INFORMANT Address <u>Bina Lavinia Everitts Brunswick, Md.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kentronal fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>acute myocardial infarction</u> DUE TO (c) <u>arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>present</u> <u>one week</u> <u>unknown</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 4</u> , 19 <u>67</u> , to <u>death</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>Aug 4</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.										22b. DATE SIGNED					
22a. SIGNATURE <u>John C. Stauffer</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u>					22d. ADDRESS <u>Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Martinsburg W. Virginia</u>							
24. FUNERAL DIRECTOR <u>Leete Funeral Home</u>					ADDRESS <u>Brunswick Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

DECLARATION OF DEATH

11-11-54

DATE OF DEATH

NAME OF DECEASED

AGE OF DECEASED

SEX OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11600 CERTIFICATE OF DEATH 11612									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN lb 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade, Box 31 31-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DEWEY First Middle Last FLAUGHER G. FLAUGHER					4. DATE OF DEATH Month Aug. Day 19 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/16/1898		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Foxville Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles E. Flaughter					14. MOTHER'S MAIDEN NAME Edith Brown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 1942-1944			16. SOCIAL SECURITY NO. 217-10-2966A		17. INFORMANT Address Mrs. Sylvia Wastler, Cascade Md., Box 119				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis/Heart Disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 10 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8/19 , 19 67 , to 8/19 , 19 67 , that (I) (we) saw the deceased alive on 8/19 , 19 67 , and that death occurred at 7:20 AM , from causes and on the date stated above.									
22a. SIGNATURE Dalton M. Welty					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/19/67		
22c. PHYSICIAN'S NAME (Type) DALTON M. WELTY					22d. ADDRESS Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/21/67		23c. NAME OF CEMETERY OR CREMATORY Bethel			23d. LOCATION (City or town) (County) (State) Lantz #1 Frederick Md.		
24. FUNERAL DIRECTOR Walter J. Grove,				ADDRESS Waynesboro Pa.		25a. REC'D BY REGISTRAR AUG 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

Yes 1902-1911 217-10-2066 Mr. Sylvia Weller, Casaca Rd., Box 112
 Charles E. Flanagan
 Plasterer
 White
 1/16/1908
 Foxville, Md.
 U.S.A.
 10 days
 Casaca, Box 31
 Washington

Yes 1902-1911 217-10-2066 Mr. Sylvia Weller, Casaca Rd., Box 112
 Charles E. Flanagan
 Plasterer
 White
 1/16/1908
 Foxville, Md.
 U.S.A.
 10 days
 Casaca, Box 31
 Washington

CERTIFICATE OF DEATH

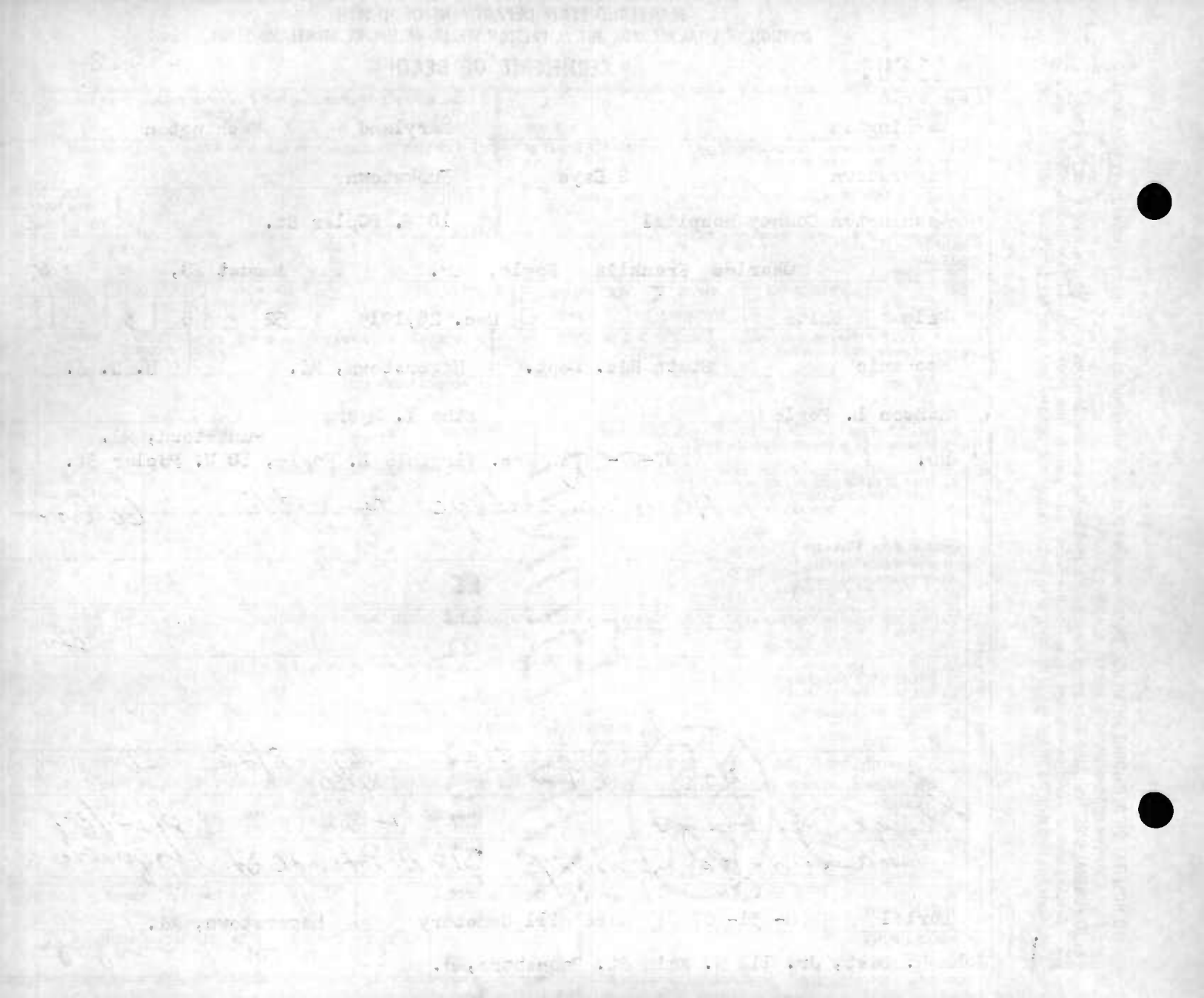
11601

11613

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 10 W. Poplar St.	
3. NAME OF DECEASED (Type or print) Charles Franklin Fogle, Sr.		4. DATE OF DEATH Month August Day 28 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1914
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 8 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY State Rds. Dept.	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hanson L. Fogle		14. MOTHER'S MAIDEN NAME Etha V. Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 207-07-5971	
17. INFORMANT Mrs. Virginia L. Fogle, 10 W. Poplar St.		18. ADDRESS Funkstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis DUE TO (b) 587.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 60 hrs.			INTERVAL BETWEEN ONSET AND DEATH 60 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/26 , 19 67 , to 8/28 , 19 67 , that (I) (we) last saw the deceased alive on 8/28 , 19 67 , and that death occurred at 4:20 p.m. from causes and on the date stated above.			
22a. SIGNATURE George Jennings		22b. DATE SIGNED 8/29/67	
22c. PHYSICIAN'S NAME (Type) George Jennings		22d. ADDRESS 318 N. Potomac St. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-31-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR DATE SEP 5 1967	
		25b. REGISTRAR'S SIGNATURE f. m. jones	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
11602					CERTIFICATE OF DEATH					11614				
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 9 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 908 Hamilton Blvd.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 908 Hamilton Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Nellie Frances Ford First Middle Last					4. DATE OF DEATH August 21, 1967 Month Day Year									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1896 yrs.		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) St. James, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Charles T. Mumma					14. MOTHER'S MAIDEN NAME Isabell Wolf									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.			16. SOCIAL SECURITY NO. 579-28-2967		17. INFORMANT Hagerstown, Md. Catherine I. Mumma, 299 Summit Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, probable DUE TO (b) Arteriosclerotic (Coronary) Heart Dis DUE TO (c) 12 years. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH Immediate				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from 6-15, 1959 , to 8-21, 1967 , that (I) (we) lost saw the deceased alive on 8-14, 1967 , and that death occurred at 10:30 P.M. , from causes on and on the date stated above.														
22a. SIGNATURE John H. Hornbaker						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-22-67						
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.						22d. ADDRESS 154 West Washington St., Hagerstown, Md. 21740								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8-24-67		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery			23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.						
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						ADDRESS		25a. REC'D BY REGISTRAR AUG 25 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

OFFICE OF THE SECRETARY

1901

Washington, D.C.

February 1, 1901

Dear Sir:

Enclosed

are the

proceedings of the

Board of

the

the

Very

Respectfully

Yours

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11603

CERTIFICATE OF DEATH

11615

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pg.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>—</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>Greencastle RD 2</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie L. FORSYTH</u>		4. DATE OF DEATH <u>August 9</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/1894</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>73</u>
11. BIRTH PLACE (County & State, or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID FORSYTH</u>		14. MOTHER'S MAIDEN NAME <u>Alice Barnhart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or (unknown)) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>198-30-1325</u>	
17. INFORMANT <u>Clyde Forsyth</u> Address <u>Greencastle Rd 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac dilatation</u> DUE TO <u>2 days</u> (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO <u>11 yrs.</u> (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/8/67</u> to <u>8/9/67</u> , that (I) (we) last saw the deceased alive on <u>8/9/67</u> 19 <u>67</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>8/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Meyer</u>		22d. ADDRESS <u>Greencastle Rd.</u>	
23a. BURIAL CREMATION, EMBALMING (Specify)	23b. DATE THEREOF <u>8/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Wash. Co. Pg.</u>
24. FUNERAL DIRECTOR <u>A. E. Munnich</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

AUG 14 1967

STANDARD FORM NO. 100-10

100-10

1. Name of Patient: [illegible]
2. Date of Birth: [illegible]
3. Sex: [illegible]
4. Race: [illegible]
5. Social Security Number: [illegible]
6. Date of Admission: [illegible]
7. Date of Discharge: [illegible]
8. Name of Discharge Facility: [illegible]
9. Name of Discharge Physician: [illegible]
10. Name of Discharge Hospital: [illegible]
11. Name of Discharge Clinic: [illegible]
12. Name of Discharge Office: [illegible]
13. Name of Discharge Department: [illegible]
14. Name of Discharge Division: [illegible]
15. Name of Discharge Branch: [illegible]
16. Name of Discharge Section: [illegible]
17. Name of Discharge Unit: [illegible]
18. Name of Discharge Team: [illegible]
19. Name of Discharge Group: [illegible]
20. Name of Discharge Project: [illegible]

21. Name of Discharge Center: [illegible]
22. Name of Discharge Institute: [illegible]
23. Name of Discharge Foundation: [illegible]
24. Name of Discharge Association: [illegible]
25. Name of Discharge Society: [illegible]
26. Name of Discharge Club: [illegible]
27. Name of Discharge League: [illegible]
28. Name of Discharge Order: [illegible]
29. Name of Discharge Chapter: [illegible]
30. Name of Discharge Council: [illegible]
31. Name of Discharge Commission: [illegible]
32. Name of Discharge Board: [illegible]
33. Name of Discharge Committee: [illegible]
34. Name of Discharge Task Force: [illegible]
35. Name of Discharge Working Group: [illegible]
36. Name of Discharge Steering Committee: [illegible]
37. Name of Discharge Advisory Board: [illegible]
38. Name of Discharge Consultative Group: [illegible]
39. Name of Discharge Liaison Committee: [illegible]
40. Name of Discharge Task Force: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11604. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11604

11616

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 125 East Antietam St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MINERVA BEULAH GARLING		4. DATE OF DEATH August 27 1967 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14 1906 60 yrs.
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Guessford		14. MOTHER'S MAIDEN NAME Catherine Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-1335	
17. INFORMANT Esther M. Myers		Address 217 Norway Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatic necrosis DUE TO 587.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute hemorrhagic gastropathy DUE TO 6-86 (c) Diathesopathy		INTERVAL BETWEEN ONSET AND DEATH 6-86	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyelonephritis; Acute - minimal		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 8/29/67		22. DATE SIGNED 8/29/67	
ACTUAL SIGNATURE Edward W. Ditto, III, M.D. EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/31/67	
23c. NAME OF CEMETERY OR CREMATORY Lutheren Cemetery		23d. LOCATION (City or Town) (County) (State) Leitersburg Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman F		25. REC'D BY REGISTRAR SEP 5 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

100-100000

WASHINGTON COUNTY, MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
11605					11617					
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN Tb 38 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 134 East Franklin Street					d. STREET ADDRESS 134 East Franklin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Isabelle George			First Middle Last		4. DATE OF DEATH Month August Day 28 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1914		9. AGE (In years last birthday) 52 yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sety Sety.			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (County & State, or foreign country) Hagerstown			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Hoover					14. MOTHER'S MAIDEN NAME Mae Haynes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-09-7120		17. INFORMANT Frank L. George Address 134 E. Franklin St Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Symphosarcoma DUE TO (b) 200.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Breast									INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 16 Oct , 19 63 , to date , 19 67 , that (I) (we) lost saw the deceased alive on 16 Oct - 1963 , and that death occurred at 8 A.M. from causes on and on the date stated above.										
22a. SIGNATURE Richard T. Binford					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 28 August 67			
22c. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.					22d. ADDRESS 1135 Potomac Avenue Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 30/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.					25a. REC'D BY REGISTRAR SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
Hagerstown, Md.										

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring #2		c. LENGTH OF STAY IN lb 24 Hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Mercersburg Road.		d. STREET ADDRESS Route #1 Union Rescue Mission	
3. NAME OF DECEASED (Type or print) George Emmert Gosnell		4. DATE OF DEATH Month Aug. Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1911
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plaster		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cearfoss, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Gosnell		14. MOTHER'S MAIDEN NAME Katherine E. Bovey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-3229	
17. INFORMANT Patricia Williams		18. ADDRESS Williamsport, Md. R. 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion - DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart Disease + DUE TO (c) generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 15-20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 14/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc Hagerstown, Maryland.		25. REC'D BY REGISTRAR DATE AUG 17 1967	
25b. REGISTRAR'S SIGNATURE John A. Judge		DATE SIGNED 8/14/67	

1918

UNITED STATES DEPARTMENT OF AGRICULTURE

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United States Department of Agriculture

United States Department of Agriculture

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CERTIFICATE OF DEATH

11619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u> c. LENGTH OF STAY IN 1b <u>YEARS</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> p. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO New Windsor</u> d. STREET ADDRESS <u>111 N. 1st St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY CATHERINE GRAYBILL</u> First Middle Last		4. DATE OF DEATH <u>AUG 11 1967</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 7 - 1879</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
10a. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		10b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. FATHER'S NAME <u>SAMUEL M. HOFF</u>		12. MOTHER'S MAIDEN NAME <u>MIRIAM MYERS</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		14. SOCIAL SECURITY NO. <u>212-50-0211</u>	
15. INFORMANT <u>WM. HOFF, WESTMINSTER, MD</u>		Address	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4500 IMMEDIATE CAUSE (a) <u>Intermalumia with senility</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 10, 1967</u> , to <u>Aug 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 10, 1967</u> and that death occurred at <u>12</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. W. Lellan</u> M.D.		22b. DATE SIGNED <u>Aug 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Boonsboro, Md.</u>		22d. ADDRESS <u>G. W. Lellan M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG 14 - 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>FREDERICK MD</u>	
24. FUNERAL DIRECTOR <u>D. D. Kuntzler & Sons New Windsor</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 15 1967</u>	

1. NAME OF THE PARTY:
 2. ADDRESS:
 3. CITY:
 4. STATE:
 5. ZIP:
 6. PHONE:
 7. FAX:
 8. E-MAIL:
 9. DATE:
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11608			
CERTIFICATE OF DEATH			
11620			
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg d. STREET ADDRESS Rear 17 E. Water St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Ann Guessford		4. DATE OF DEATH Month August Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1966
9. AGE (In years lost birthday) yrs. 0		10. IF UNDER 1 YEAR Months 11 Days 29 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md.	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Larry Guessford		14. MOTHER'S MAIDEN NAME Paulette Snyder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Larry Guessford, Smithsburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO (b) Congestive Failure - Congenital Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 			
19. INTERVAL BETWEEN ONSET AND DEATH 1 yr.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 28, 1967 to Aug 28, 1967 , that (I) (we) last saw the deceased alive on Aug 28, 1967 and that death occurred at 1:40 PM from causes and on the date stated above.			
22a. SIGNATURE J. D. Wilson		22b. DATE SIGNED 8/28/67	
22c. PHYSICIAN'S NAME (Type) J. D. WILSON		22d. ADDRESS HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-29-67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. DATE AUG 31 1967	

CERTIFICATE OF DEATH

County of ... State of ...

City of ...

My name is ...

of the County of ...

State of ...

and in the County of ...

State of ...

on the ... day of ...

at the City of ...

in the County of ...

State of ...

My name is ...

of the County of ...

and in the County of ...

State of ...



Witness my hand and seal this ... day of ...

at the City of ...

in the County of ...

State of ...

My name is ...

of the County of ...

State of ...

and in the County of ...

State of ...

My name is ...

of the County of ...

State of ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. 1, Clear Spring, Md. d. STREET ADDRESS 211						
3. NAME OF DECEASED (Type or print) First Middle Last Lloyd Evers Guessford						4. DATE OF DEATH Month Day Year Aug 30 19 67						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1911		9. AGE (In years last birthday) 56 yrs.		10. IF FUNERAL 1 YEAR IF FUNERAL 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator						10b. KIND OF BUSINESS OR INDUSTRY Construction			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Guessford						14. MOTHER'S MAIION NAME Minnie Hawbaker						
15. WAS OCEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 212-50-8452		17. INFORMANT Howard Guessford RFD1, Clear Spring				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. OEAETH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending Acute subdural hematoma 936.9 DUE TO (b) Fracture of skull, occipital Cerebral contusion and laceration DUE TO (c) Cirrhosis of liver										INTERVAL BETWEEN ONSET AND OEAETH Not known Several years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -			20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.						22. OATE SIGNED 9-1-67 Address (Street, city, town, or county) Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. OATE THEREOF Sept. 2, 67			23c. NAME OF CEMETERY OR CREMATORY Little Rose Hill			23d. LOCATION (City, town or county) (State) Clear Spring, Md.			
24. FUNERAL DIRECTOR Thompson Funeral Home Clear Spring Md.						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge						

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY
CHICAGO, ILLINOIS 60637
U.S.A.

TO THE DIRECTOR, NATIONAL BUREAU OF STANDARDS
WASHINGTON, D.C. 20535

RE: [Illegible]

[Illegible text follows, including a signature and date]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

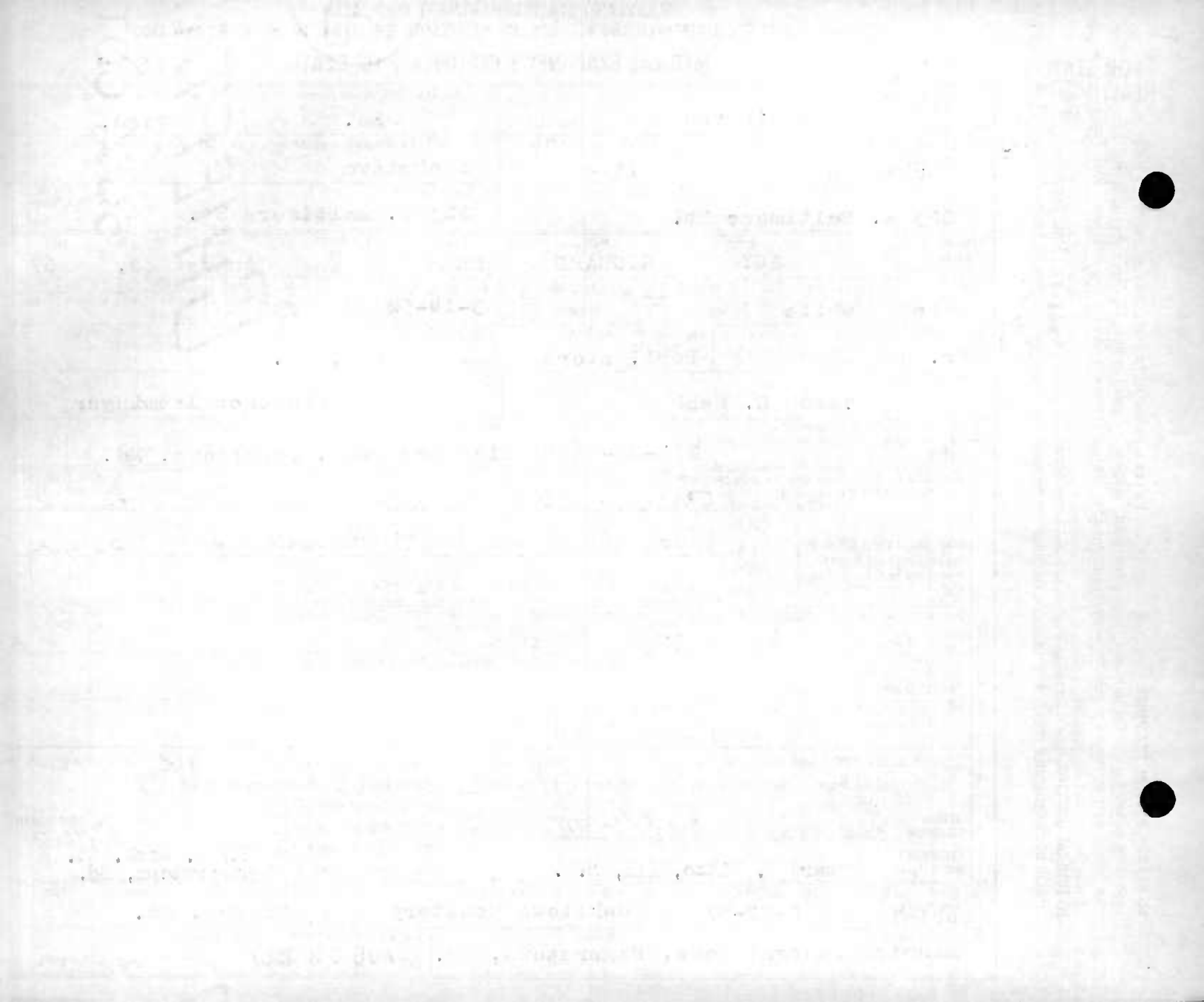
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11610

11622

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 225 E. Baltimore St.		e. STREET ADDRESS 225 E. Baltimore St.	
3. NAME OF DECEASED (Type or print) First GUY Middle RICHARD Last HEBB		4. DATE OF DEATH Month August Day 20 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-92
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mgn. and buyer		10b. KIND OF BUSINESS OR INDUSTRY Dept. store	
11. BIRTHPLACE (State or foreign country) Funkstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph H. Hebb		14. MOTHER'S MAIDEN NAME Florence Iseminger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-0689	
17. INFORMANT Florence Hebb, Funkstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic heart disease DUE TO (c) General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostate hypertrophy, Benign			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 8/21/67	
Address (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-22-67	
23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		23d. LOCATION (City or Town) (County) (State) Funkstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 23 1967	
		25b. REGISTRAR'S SIGNATURE James J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11611

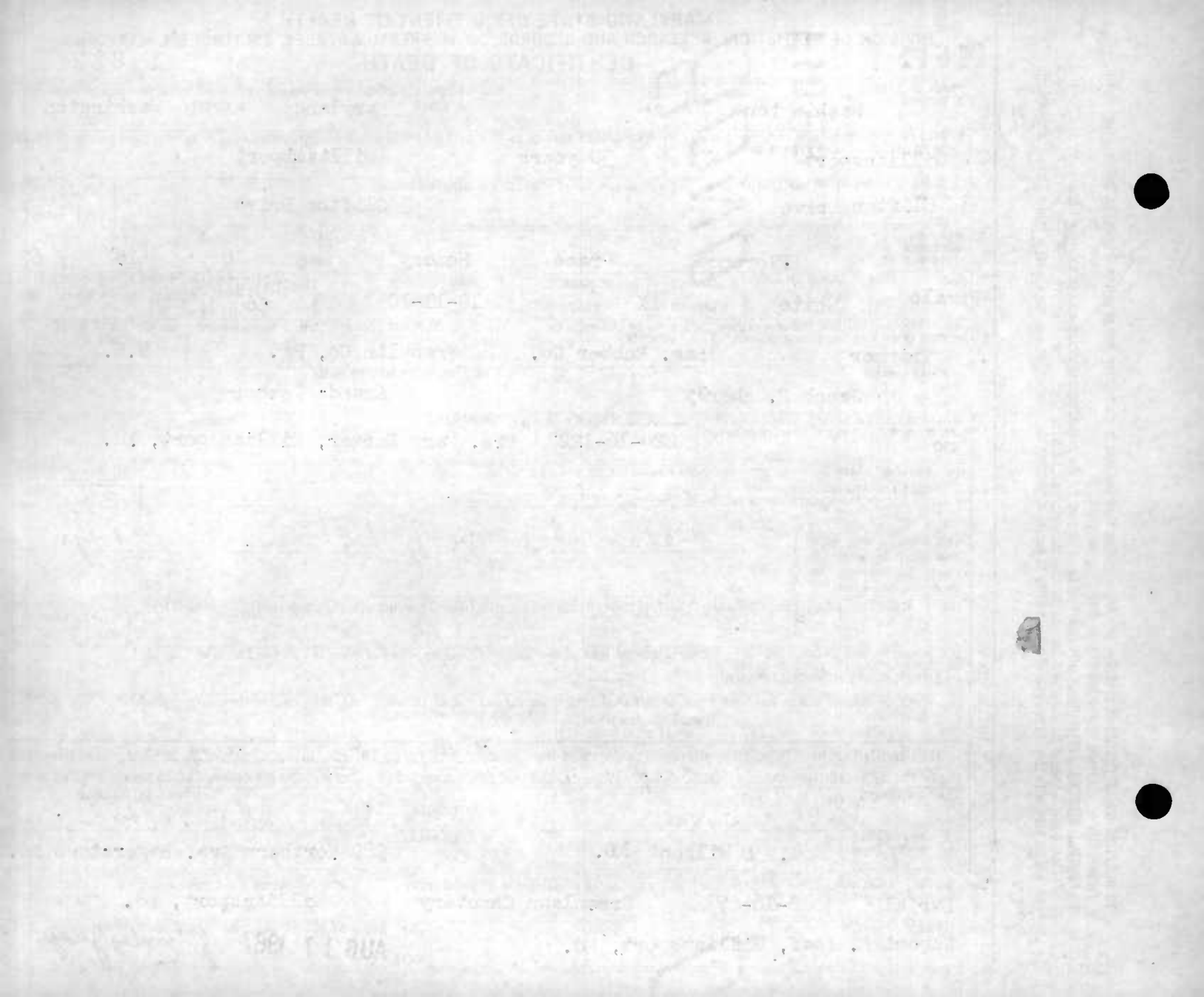
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11623

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3 Clifton Drive</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>3 Clifton Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Grace</u> Last <u>Henesy</u>		4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>19 67</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-10</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trimmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hag. Rubber Co.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Jacob H. Eberly</u>						14. MOTHER'S MAIDEN NAME <u>Amanda Leshner</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-16-1228</u>		17. INFORMANT Address <u>Mrs. Mary Carter, Williamsport, Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Anoxia</u> 174X DUE TO (b) <u>Metastatic Ca of Uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>1 yr.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>66</u> , to <u>14 Aug</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10 Aug</u> 19 <u>67</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>J. D Wilson</u>														22b. DATE SIGNED <u>8/15/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. D Wilson MD.</u>				22d. ADDRESS <u>580 Northern Ave. Hagerstown Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Williamsport, Md.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Albert L. Leaf, Williamsport, Md.</u>						25a. REC'D BY REGISTRAR <u>AUG 17 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



FOR STATE HEALTH DEPT. **1**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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99

Items 18&20f Film 392		MARYLAND STATE DEPARTMENT OF HEALTH	
9-5-67 ams		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
11612		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
11624			
1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Gapland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Kelley Michelle Holder		4. DATE OF DEATH August 4, 19 67	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 9, 1966	
9. AGE (In years lost birthday) 1 yrs.		IF UNDER 1 YEAR Months 5 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ricky L. Holder		14. MOTHER'S MAIDEN NAME Erenda Danner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Ricky L. Holder, Gapland, Md.		Address Gapland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 962 X IMMEDIATE CAUSE (a) Bilateral Chylothorax due to Rupture of Thoracic Duct DUE TO (b) Old injury of L2 Vertebra with old laceration of anterior longitudinal ligament DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 or 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		22. DATE SIGNED 8/4/67	
ACTUAL SIGNATURE John H. Bast, Jr. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-6-67	
23c. NAME OF CEMETERY OR CREMATORY Brownsville Hgts. Cem.		23d. LOCATION (City or Town) (County) (State) Brownsville, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR AUG 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1113

Washington

England

Washington

England

U. S. A.

Washington

Washington County, Maryland

August 3, 1900

Robert

Morgan

Robert

Wm.

Wm.

Washington County, Md.

Wm.

Robert Morgan

Robert Morgan

Washington County, Md.

Wm.

Wm.

Washington County, Md.

Washington County, Md.

Washington County, Md.

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Washington County, Md.

Washington County, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11613					11625				
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> d. STREET ADDRESS <u>Reid Road, Rte 6</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward Hose, Sr.</u>			4. DATE OF DEATH Month Day Year <u>August 23 1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1919</u>		9. AGE (In years last birthday) <u>48 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book-keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Organ Parts Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles D. Hose</u>					14. MOTHER'S MAIDEN NAME <u>Amanda Griffin</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-1144</u>		17. INFORMANT <u>Mrs. Mildred Hose</u>		Address <u>Reid Road, Rt. 6 Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Essential hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 16, 1967</u> , to <u>Aug. 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 23, 1967</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. Charles C. Spencer</u>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles C. Spencer</u>					22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport, Wash. Maryland</u>			
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>					ADDRESS <u>7 Church, St. Williamsport, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>		
					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

CERTIFICATE OF DEATH

Corbin Thompson

Diabetes mellitus

[Signature]

AUG 2 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11614

11626

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>214 W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLOYD</u> Middle <u>RENO</u> Last <u>JAMISON</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>19 67</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15 1906</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Silk Mill</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Josiah Jamison</u>			14. MOTHER'S MAIÖEN NAME <u>Minnie F. Grey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-28-2262</u>		17. INFORMANT <u>Mrs. Martha Grove Sharpsburg, Md..</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Superior vena caval obstruction</u> DUE TO (c) <u>Cancer of the lung</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas V. Craig</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/4/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Thomas V. Craig</u>		22d. ADDRESS <u>Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug.. 7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg Md.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Md.</u>				25a. REC'D BY REGISTRAR OATE <u>AUG 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

General Adams
Superior Canal Construction
General of the Army

8/4/67

+

Thomas V. Crain

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11615

CERTIFICATE OF DEATH

11627

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 23 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown,		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1220 Murdock Ave.	
d. STREET ADDRESS 1220 Murdock Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last King		4. DATE OF DEATH Month August Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1899
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason	
10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Wash. Co. Md U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George King	
14. MOTHER'S MAIDEN NAME Laura Springer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) None	
16. SOCIAL SECURITY NO. 214-04-2229		17. INFORMANT Mrs. Blanch King Address 1220 Murdock Ave. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atrial fibrillation & congestive heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m. none		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (this hospital) attended the deceased from Aug 1961 , 19__, to Aug 25, 1967 , that (I) (we) last saw the deceased alive on Aug 25 , 1967, and that death occurred at PM M, from causes and on the date stated above.			
22a. SIGNATURE Harold R. Tritch, Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Harold R. Tritch, Jr M.D.		22d. ADDRESS 302 N. Potomac Street Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 29/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		25a. REC'D BY REGISTRAR SEP 5 1967	
25b. REGISTRAR'S SIGNATURE James Judge		25c. REGISTRAR'S SIGNATURE	

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Washington

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1350 Wisconsin Ave.

August 14, 1950

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August 14, 1950

August 14, 1950

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11616 CERTIFICATE OF DEATH 11628											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 47 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 Delwood Ave.					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 6 Delwood Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Nellie Middle Margaret Last Kirk			4. DATE OF DEATH Month August Day 22 Year 19 67								
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-5-89		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Chambersburg, Penna.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles Gerbig					14. MOTHER'S MAIDEN NAME Minnie Flack						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Charles A. Kirk, Winchester, Va. Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterograde Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of the urinary bladder										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 12/11, 19 61 to 8/16 , 19 67 , that (I) (we) last saw the deceased alive on 8/16 , 19 67 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE William O. Rexrode 22c. PHYSICIAN'S NAME (Type) Dr. William O. Rexrode					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.					22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-24-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.				
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. ADDRESS				25a. REC'D BY REGISTRAR AUG 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

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11617

CERTIFICATE OF DEATH

11629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 153	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS Corriganville	
3. NAME OF DECEASED (Type or print) Cecil Elmer Kline		4. DATE OF DEATH Month Aug. Day 8 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly Springfield Tire Company		10b. KIND OF BUSINESS OR INDUSTRY Tire Company	9. AGE (In years last birthday) 67 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick Kline		14. MOTHER'S MAIDEN NAME IDA Doffenbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-5478	
17. INFORMANT Mrs. Cecil E. Kline, Corriganville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart failure DUE TO (b) Hypertensive Heart disease DUE TO (c) 134.		INTERVAL BETWEEN ONSET AND DEATH 480	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 8, 1967 , to Aug 8, 1967 , that (I) (we) last saw the deceased alive on Aug. 8, 1967 , and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Nevarro Layzequilla		22b. DATE SIGNED 8-9-67	
22c. PHYSICIAN'S NAME (Type) NEVARRO LAYZEQUILLA		22d. ADDRESS Western Md. State Hosp. Hagerstown, Md.	
23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION BURIAL	23b. DATE THEREOF August 12, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or town) (County) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR HARVEY H. ZEIGLER, HYNDMAN, PENNSYLVANIA		25a. REC'D BY REGISTRAR AUG 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

Age 12.2
Cause of Death
Diphtheria

Place of Birth
New York City

Age 8
Cause of Death
Diphtheria

Place of Birth
New York City

Age 13.7
Cause of Death
Diphtheria

Place of Birth
New York City

Age 13.7
Cause of Death
Diphtheria

Place of Birth
New York City

Age 8.7
Cause of Death
Diphtheria

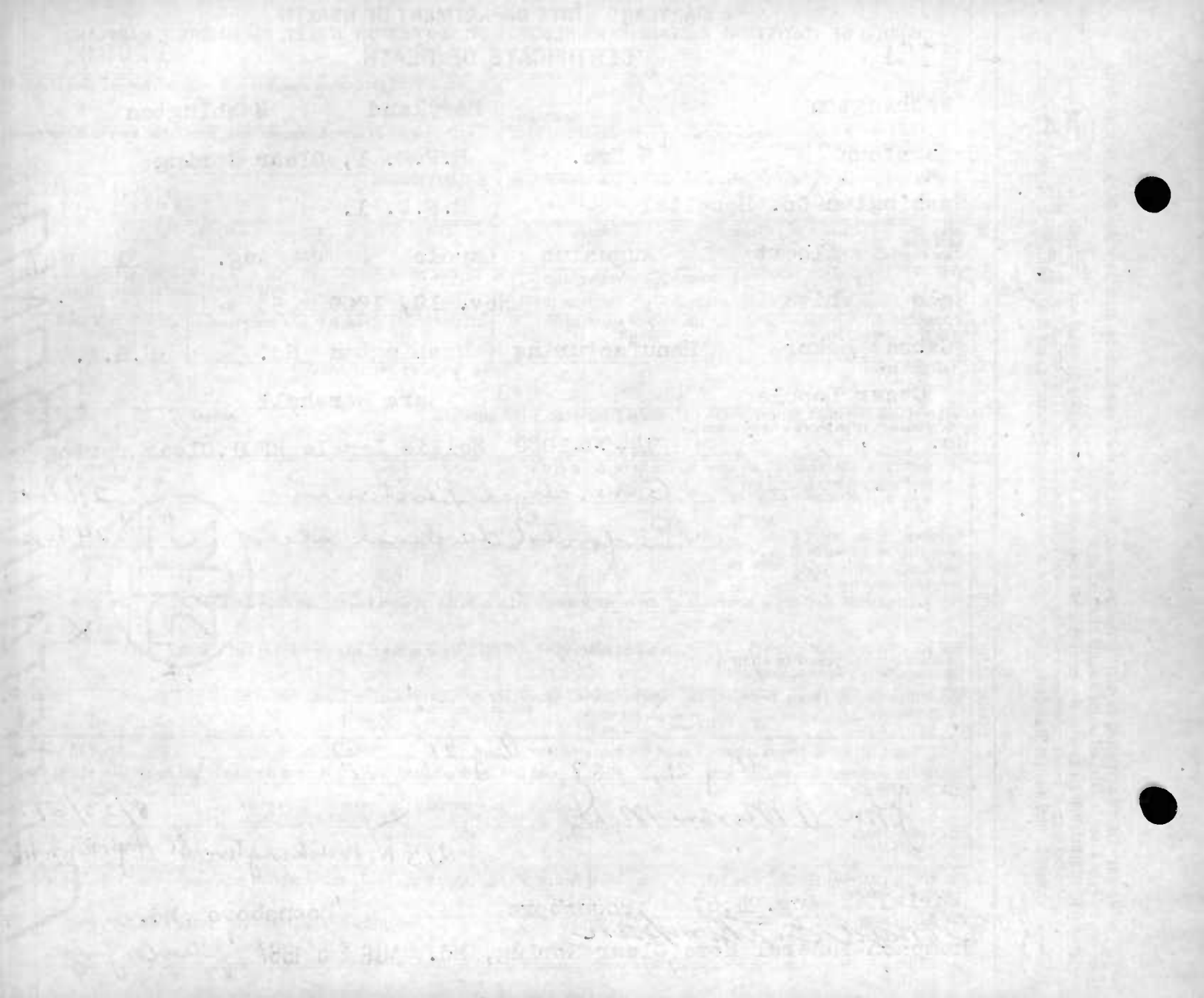
Place of Birth
New York City

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VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> 11618 <div> <div>HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> </div> <div> <div>CERTIFICATE OF DEATH</div> <div>11630</div> </div> </div>										
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 Hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. 1, Clear Spring					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital					d. STREET ADDRESS R.F.D. 1.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Albert Augustus Lapole					4. DATE OF DEATH Month Day Year Aug. 21 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19, 1909		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (County & State, or foreign country) Washington Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Oscar Lapole					14. MOTHER'S MAIDEN NAME Sara Marshall					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-09-1080		17. INFORMANT Nellie Lapole		Address RFD1, Clear Spring				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5411 Generalized Peritonitis DUE TO (b) Perforated duodenal ulcer DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Aug 21, 1967, to , 19 , that (I) (we) last saw the deceased alive on Aug 21, 1967, and that death occurred at 1 P.M. from the causes and on the date stated above.										
22a. SIGNATURE John A. Moran M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/23/67			
22c. PHYSICIAN'S NAME (Type) Thompson Funeral Home					22d. ADDRESS 215 W. Washington St Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 24, 67		23c. NAME OF CEMETERY OR CREMATORY Boonsboro		23d. LOCATION (City, town or county) (State) Boonsboro Md				
24. FUNERAL DIRECTOR Donald E. Thompson					25a. REC'D BY REGISTRAR AUG 25 1967					25b. REGISTRAR'S SIGNATURE Charles Judge



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 218 NORWAY AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 218 NORWAY AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES CALVIN LEFEVER		4. DATE OF DEATH Month AUGUST Day 26 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1881
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST	
11. BIRTHPLACE (County & State, or foreign country) FUNKSTOWN, MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE C. LEFEVER		14. MOTHER'S MAIDEN NAME MARY J. MILLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) ****		16. SOCIAL SECURITY NO. 214-09-1045	
17. INFORMANT MRS. HARRY HAUSE,		Address 218 NORWAY AVENUE, HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Recent 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Jan. 2, 1967 , to Aug. 26, 1967 , that (I) (we) last saw the deceased alive on July 21, 1967 , and that death occurred at 7:20 M. from causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto, Jr.		22b. DATE SIGNED AUGUST 28, 1967	
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, JR.		22d. ADDRESS 215 W. WASHINGTON ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/29/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR AUG 30 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

NOTARY PUBLIC

STATE OF NEW YORK

DECEASED

NAME

AGE

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

U.S.A.

U.S.A.

U.S.A.

U.S.A.

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U.S.A.

U.S.A.

7-257357

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>47.3</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> Washington		d. STREET ADDRESS <u>1660 Trinidad Ave. N.E.</u> <u>5214 HASTINGS BLVD. ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY</u>		First <u>GIRL</u>		Middle <u>LOVE</u>		Last	
4. DATE OF DEATH <u>AUGUST 5</u>		Month <u>1967</u>		Day		Year	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 5-67</u>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) yrs. <u>8</u>		IF UNDER 1 YEAR Months <u>40</u>		IF UNDER 24 HRS. Hours <u>40</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON Co. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>JANICE LOVE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MOTHER & BABY'S CHART</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>7735</u> IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-5</u> , 19 <u>67</u> , to _____, 19____, that (I) (we) lost saw the deceased alive on <u>8-5</u> 19 <u>67</u> , and that death occurred at <u>11:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>A. M. Mandell</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A.M. MANDELL MD</u>				22d. ADDRESS <u>301 E. ANT ST HAG.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>AUGUST 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON COUNTY HOSPITAL HAGERSTOWN, MARYLAND</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>John Schaffner, Adm. Wash Co. Hosp.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11621

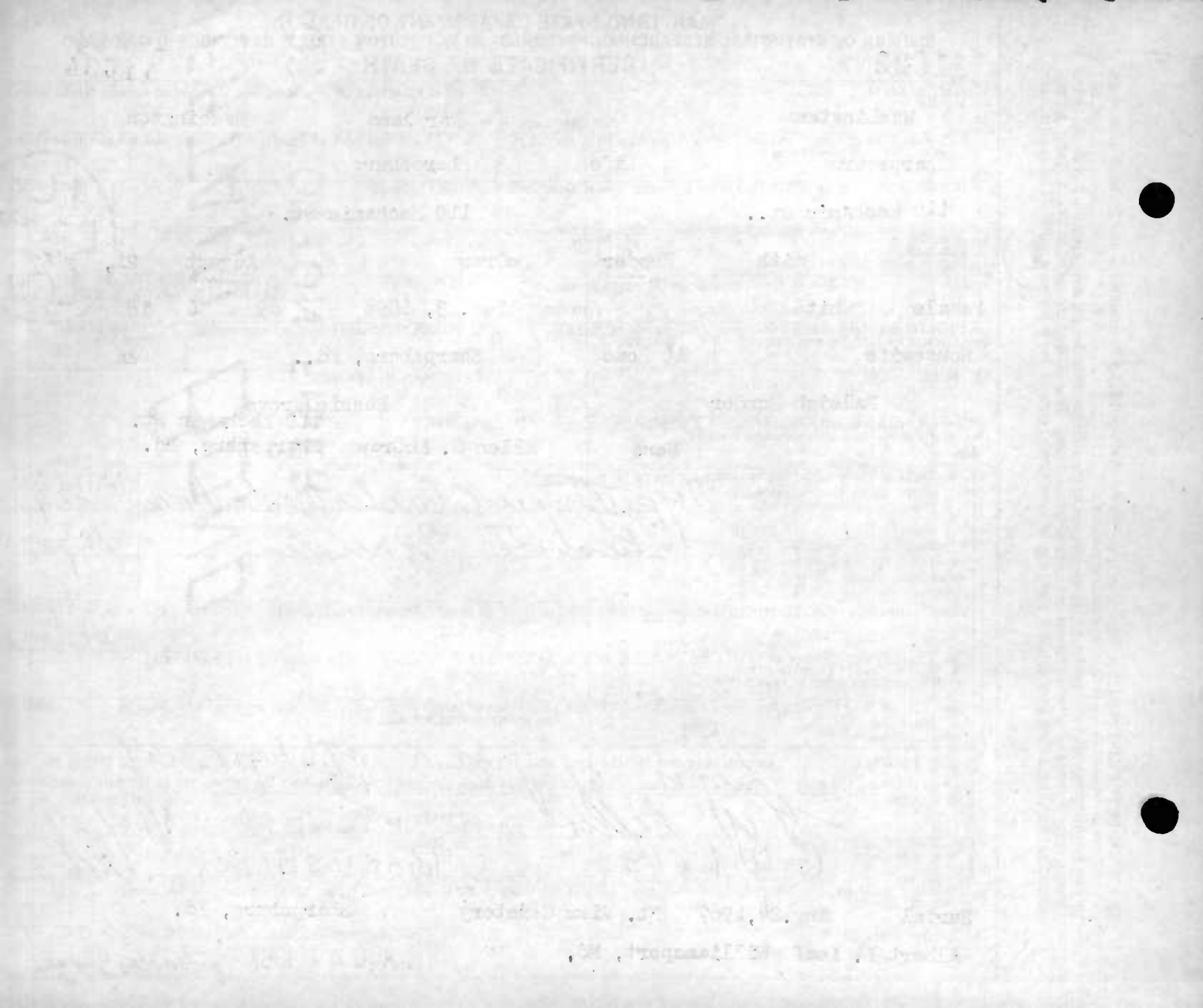
11633

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY FRANKLIN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MERCERSBURG	
c. LENGTH OF STAY IN lb LIFE		d. STREET ADDRESS 125 LOUDEN ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 716 INTERVAL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD WILLIAM MARKLE		4. DATE OF DEATH Month Day Year August 2, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 2, 1945
9. AGE (In years less birthday) yrs. 22		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE CO.	
11. BIRTHPLACE (State or foreign country) GREENSBURG, PENNSYLVANIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS EUGENE MARKLE		14. MOTHER'S MAIDEN NAME IDA BAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 205-34-9607	
17. INFORMANT MRS. REBECCA M. MARKLE, MERCERSBURG, PENNA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Working on automobile in garage with doors all closed.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8-2- 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) EDWARD W. DITTO, JR. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 8/8/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/9/67	
23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY		23d. LOCATION (City or town) (County) (State) RINGGOLD, WASH. CO. MARYLAND	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR AUG 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11622					11634						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Washington MARYLAND					a. STATE Maryland b. COUNTY Washington						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 110 Mechanic St..					d. STREET ADDRESS 110 Mechanic St.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First Edith Middle Bender Last McGraw					Month August Day 21, Year 1967						
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 69 yrs.			
Female		White				Feb. 3, 1898		IF UNDER 1 YEAR Months 6 Days 18 Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (County & State, or foreign country) Sharpsburg, Md..			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Raleigh Bender					14. MOTHER'S MAIDEN NAME Bessie Grove						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT Allen G. McGraw			110 Mechanic St. Sharpsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Hypertensive Cardiovascular Disease DUE TO (b) Diabetes Mellitus DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from June 10, 1967, to Aug 21, 1967, that (I) (we) last saw the deceased alive on Aug 21, 1967, and that death occurred at 4:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE G. W. Lefler					22b. DATE SIGNED 8/24/67						
22c. PHYSICIAN'S NAME (Type) G. W. Lefler					22d. ADDRESS 1300 S. B. Rd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug. 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery			23d. LOCATION (City, town or county) (State) Sharpsburg, Md.			
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.					25a. REC'D BY REGISTRAR AUG 24 1967					25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CP

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegeny</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 1, Frostburg</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Elizabeth</u> Last <u>Michaels</u>						4. DATE OF DEATH Month <u>Aug.</u> Day <u>9</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24, 1916</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANTON URBAS</u>						14. MOTHER'S MAIDEN NAME <u>TERESA LICKAR</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>BERNARD MICHAELS, RT. 1, FROSTBURG, MD.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular Failure</u> DUE TO (b) <u>mitral stenosis & insufficiency</u> DUE TO (c) <u>Rheumatic heart disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>35 years</u> <u>42 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Bacterial endocarditis (2) multiple infarction (kidneys & spleen)</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) <u>(his hospital)</u> attended the deceased from <u>July 13</u> , 19 <u>67</u> , to <u>Aug. 9</u> , 19 <u>67</u> , that (1) <u>(me)</u> saw the deceased alive on <u>Aug. 9</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above											
22a. SIGNATURE <u>Victor L. Ramos</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Aug. 9, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>						22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAELS CEMETERY</u>				23d. LOCATION (City or Town) (County) (State) <u>FROSTBURG, MD.</u>			
24. FUNERAL DIRECTOR <u>JOSEPH R. DURST, SR., FROSTBURG, MD.</u>						ADDRESS <u>21532</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF MARRIAGE

I hereby certify that on the 21st day of August 1901
 at the City of New York
 I have joined together in Holy Matrimony
 the following persons:
 The said _____ of the County of _____
 and the said _____ of the County of _____
 in the presence of _____
 and _____
 who are duly qualified witnesses.
 In testimony whereof I have hereunto set my hand and the seal of my office
 at the City of New York, this _____ day of _____ 1901.

 Minister of the Gospel

I hereby certify that on the _____ day of _____ 1901
 at the City of New York
 I have joined together in Holy Matrimony
 the following persons:
 The said _____ of the County of _____
 and the said _____ of the County of _____
 in the presence of _____
 and _____
 who are duly qualified witnesses.
 In testimony whereof I have hereunto set my hand and the seal of my office
 at the City of New York, this _____ day of _____ 1901.

 Minister of the Gospel

I hereby certify that on the _____ day of _____ 1901
 at the City of New York
 I have joined together in Holy Matrimony
 the following persons:
 The said _____ of the County of _____
 and the said _____ of the County of _____
 in the presence of _____
 and _____
 who are duly qualified witnesses.
 In testimony whereof I have hereunto set my hand and the seal of my office
 at the City of New York, this _____ day of _____ 1901.

 Minister of the Gospel

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Items 18-21 Film 392
9-11-67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11624

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11636

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.	
3. NAME OF DECEASED (Type or print) First Samuel Middle Garfield Last Moore		4. DATE OF DEATH Month Aug. Day 4 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1915
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Two Guys Store	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel G. Moore Sr.		14. MOTHER'S MAIDEN NAME Anna Patterson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941 to 1944		16. SOCIAL SECURITY NO. 119-10-2358	
17. INFORMANT Mrs. Marie Moore, 128 S. Prospect St.		Address Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending/ Ruptured spleen with perisplenic hema- DUE TO toma and massive peritoneal hemorrhage (b) Acute pancreatitis, recurrent DUE TO (c) Arteriosclerotic heart disease, mild			INTERVAL BETWEEN ONSET AND DEATH Recent
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. M.D.		22. DATE SIGNED 8-5-67	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/6/67	23c. NAME OF CEMETERY OR CREMATORY Harbaugh	23d. LOCATION (City or Town) (County) (State) Rural Franklin Co. Pa.
24. FUNERAL DIRECTOR Walter Z. Grove		ADDRESS Waynesboro Pa.	
25a. REC'D BY REGISTRAR DATE AUG 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

Washington

1941

Washington

Washington, D.C.

12 hours

Washington

121 S. Potomac St.

Washington County Hospital

12 hours

12 hours

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12 hours

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12 hours

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 10&21 Film 391 8-14-67 and		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11637	
11625				MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Rear 52½ E. Antietam, St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lloyd Edwin Murray		4. DATE OF DEATH Month Aug. Day 4 Year 1967		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Sept. 14, 1910 9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Hagerstown, MD.	
13. FATHER'S NAME Harry Murray		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW2		16. SOCIAL SECURITY NO. 214-09-7784		17. INFORMANT Daniel Murray Address Clearspring Rl Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending Lobular pneumonia, bilateral with aspiration of fluid DUE TO (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary atherosclerosis, severe				INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 8-5-67	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/67		23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery	
24. FUNERAL DIRECTOR Andrew K. Coffmann Funeral Home Inc		23d. LOCATION (City or Town) (County) (State) Broadfording, Washington, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge			

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Washington County Hospital

Washington County Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item#9 Film#G391 8/11/67 ph

CERTIFICATE OF DEATH

11638

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 40 EAST WASHINGTON STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE ROOSEVELT MYERS		4. DATE OF DEATH Month Day Year AUGUST 2, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCTOBER 27, 1904
9. AGE (In years last birthday) 62 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) DRILL PRESS OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY METAL MFG.	
11. BIRTHPLACE (County & State, or foreign country) HAGERSTOWN, WASH.CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN S. MYERS		14. MOTHER'S MAIDEN NAME ALICE V. HICKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-5592	
17. INFORMANT REV. G. HAROLD MYERS, THOMASVILLE, N.C.		18. ADDRESS 116 SALEM STREET,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Atherosclerosis DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH minutes 4pm.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) not present attended the deceased from Dec. 1966 to July 1967 , that (I) not saw the deceased alive on 7-2-67 and that death occurred at 8:30 A.M. from causes and on the date stated above.		22a. SIGNATURE D.J. Boyer M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DAVID J. BOYER, M.D.		22d. ADDRESS 136 N. POTOMAC ST. HAGERSTOWN, MD.	
22b. DATE SIGNED AUGUST 3, 1967		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 8/4/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY,	
23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.		24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.	
25a. REC'D BY REGISTRAR DATE AUG 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

CRIMINAL DIVISION

WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11627					11639				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Washington MARYLAND					b. STATE Maryland c. COUNTY Washington				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport R #2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 18 Short Drive				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last RUBY Margaret NICODEMUS					Month Day Year August 24 19 67				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 29 1914		53 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Elmer Anthony					14. MOTHER'S MAIDEN NAME Maudie Troxell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. ---		17. INFORMANT Leonard C. Nicodemus			Address 18 Short Dr. Williamsport Md R #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperglycemia & Acidosis with coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis, cerebral; Ecthyma, lower legs									INTERVAL BETWEEN ONSET AND DEATH 6 hours Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the physician) attended the deceased from August 23, 1967 to Aug. 24, 1967 , that (I) last saw the deceased alive on August 23, 1967 , and that death occurred at 2:15 PM , from the causes and on the date stated above.									
22a. SIGNATURE 					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED August 24, 1967	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.					22d. ADDRESS 100 Professional Arts Bldg, Hag., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/26/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.		
24. FUNERAL DIRECTOR Andrew K. Coffman					ADDRESS Hagerstown Md		25a. REC'D BY REGISTRAR AUG 28 1967		25b. REGISTRAR'S SIGNATURE 

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Hyperlipidemia & Atherosclerosis with some

hyperlipidemia

Hyperlipidemia & Atherosclerosis with some

hyperlipidemia

Atherosclerosis, coronary; atherosclerosis, lower legs

August 24

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August 24

100 Professional Arts Bldg, Wash., D.C.

William T. Layman, M.D.

August 24

August 24

August 24

August 24

August 24

August 24

August 24

August 24

11628

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> c. LENGTH OF STAY IN 1b <u>14 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> d. STREET ADDRESS <u>56 1/2 Blooms Alley</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Emma O'Neal</u> First Middle Last 4. DATE OF DEATH <u>Aug 21 19 67</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 5 1913</u> 9. AGE (In years last birthday) <u>54</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Lancaster, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George Milburn</u> 14. MOTHER'S MAIDEN NAME <u>Mercer Milburn</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mrs. Margaret James Hagerstown Md.</u> Address <u>187 W. Bethel St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> , 19 <u>63</u> , to <u>8/20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/20/67</u> at <u>2 P.M.</u> , and that death occurred on the date stated above.			
22a. SIGNATURE <u>William O. Rexrode</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Dr. William O. Rexrode</u>		22b. DATE SIGNED _____ 22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-26-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR <u>John R Watson Jr.</u> ADDRESS <u>Hagerstown Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 25 1967</u>	

CERTIFICATE OF DEATH

1912

State of New York, County of New York, City of New York.

I, the undersigned, a duly qualified and licensed physician, do hereby certify that

on the _____ day of _____, 1912, at _____, New York, I attended _____

who died at _____, New York, at the age of _____ years, _____ months, and _____ days.

The cause of death was _____

as evidenced by the following signs and symptoms: _____

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11629

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11641

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS Route 5, (Bowling Green)	
3. NAME OF DECEASED (Type or print) EMMA REBECCA O'NEILL		4. DATE OF DEATH Month August Day 20 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1887
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Moreland		14. MOTHER'S MAIDEN NAME Sarah C. Lish	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-46-3436	
17. ADDRESS (Daughter) 229 Balto. Ave.		18. ADDRESS (Daughter) Mrs. Wilma Wilkins, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive GI hemorrhage & shock due to DUE TO (b) Duodenal ulcer - secondary to DUE TO (c) Intertrochanteric fracture left femur			
INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs 2 1/2 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall at home - Fractured left hip	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 8, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland Allegany Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Dittus		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Dittus		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/23/67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Family Cem.		23d. LOCATION (City or Town) (County) (State) Near Gorman, Maryland	
24. FUNERAL DIRECTOR Leighton-Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR AUG 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 8/21/67	

1944
WASHINGTON
Bureau of
Investigation
Division of
Criminal
Inquiry
Report of
Special Agent
in Charge
Date
To
From
Subject
Reference
Enclosure
Signature
Special Agent
in Charge
Bureau of
Investigation
Division of
Criminal
Inquiry
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
11630									
11642									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 65 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 59 Randolph Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First George Middle William Last Packett					4. DATE OF DEATH Month August Day 7 Year 1967				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1882		9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pipe worker			10b. KIND OF BUSINESS OR INDUSTRY organ mfg.			11. BIRTHPLACE (County & State, or foreign country) Middleway, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James W. Packett					14. MOTHER'S MAIDEN NAME Ella M. Brining				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 214-09-8591		17. INFORMANT James W. Packett, Hagerstown, Md. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis - Generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 yrs. ±	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1967 , to July 7, 1967 , that (I) (we) last saw the deceased alive on July 7, 1967 , and that death occurred at 8 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Lloyd A. Hoffman M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 8/8/67				
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman					22d. ADDRESS 214 N. Pot. St. Hagerstown, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-10-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. ADDRESS					25a. REC'D BY REGISTRAR AUG 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11631

CERTIFICATE OF DEATH

11643

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Martin Palamar		4. DATE OF DEATH Month Day Year August 8, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1967
9. AGE (In years lost birthday) yrs. 0		10. IF UNDER 1 YEAR Months Days 0 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas M. Palamar		14. MOTHER'S MAIDEN NAME Bonnie D. Line	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas M. Palamar		Address Rfd. 1 Sharpsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION DUE TO (b) PARALYTIC ILEUS DUE TO (c) RETROPERITONEAL INFECTION - INVOLVING APPENDIX			INTERVAL BETWEEN ONSET AND DEATH 24 hr 24 hr 24 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7 Aug, 1967 , to 8 Aug, 1967 , that (I) (we) last saw the deceased alive on 8 Aug, 1967 , and that death occurred at 8:55 AM , from causes and on the date stated above.			
22a. SIGNATURE John R. Marsh M.D.		22b. DATE SIGNED 8/8/67	
22c. PHYSICIAN'S NAME (Type) John R. Marsh, M.D.		22d. ADDRESS 247 North Potomac Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-9-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR DATE AUG 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DECLARATION OF JURY

Subscribed and sworn to before me this _____ day of _____, 19____.

Notary Public for the State of _____.

My commission expires on _____ day of _____, 19____.

Witness my hand and seal this _____ day of _____, 19____.

Notary Public for the State of _____.

My commission expires on _____ day of _____, 19____.

Witness my hand and seal this _____ day of _____, 19____.

Notary Public for the State of _____.

My commission expires on _____ day of _____, 19____.

Witness my hand and seal this _____ day of _____, 19____.

Notary Public for the State of _____.

My commission expires on _____ day of _____, 19____.

Witness my hand and seal this _____ day of _____, 19____.

Notary Public for the State of _____.

My commission expires on _____ day of _____, 19____.

Witness my hand and seal this _____ day of _____, 19____.

Notary Public for the State of _____.

My commission expires on _____ day of _____, 19____.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSPORT			c. LENGTH OF STAY IN 1b 4 MOS. 22 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WILLIAMSPORT SANITARIUM					d. STREET ADDRESS 215 BRYAN PLACE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY MADELEINE PEER					4. DATE OF DEATH Month Day Year AUGUST 7 1967				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 30, 1892		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) EMMITSBURG, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH F. LINGG					14. MOTHER'S MAIDEN NAME KATHERINE BENTZ				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ****		16. SOCIAL SECURITY NO. 220-05-6161		17. INFORMANT MRS. DOLORES KENDRICK			Address 1418 W. CHURCH ST. HAGERSTOWN, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Vascular Disease DUE TO (c) Paralysis Agitans								INTERVAL BETWEEN ONSET AND DEATH 6 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 3, 1967 to Aug. 7, 1967 , that (I) (we) saw the deceased alive on Aug. 5, 1967 , and that death occurred at 1:25 PM , from causes and on the date stated above.									
22a. SIGNATURE <i>Edward W. Ditto, Jr.</i> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED AUGUST 8, 1967		
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, JR. M.D.					22d. ADDRESS 215 W. WASH. ST. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/10/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.		
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND					25a. REC'D BY REGISTRAR AUG 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

DECLARATION OF DEPENDENCY

WASHINGTON

WESTING

WASHINGTON

WESTING

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

79

VR A15 (4)
20 M 1/66

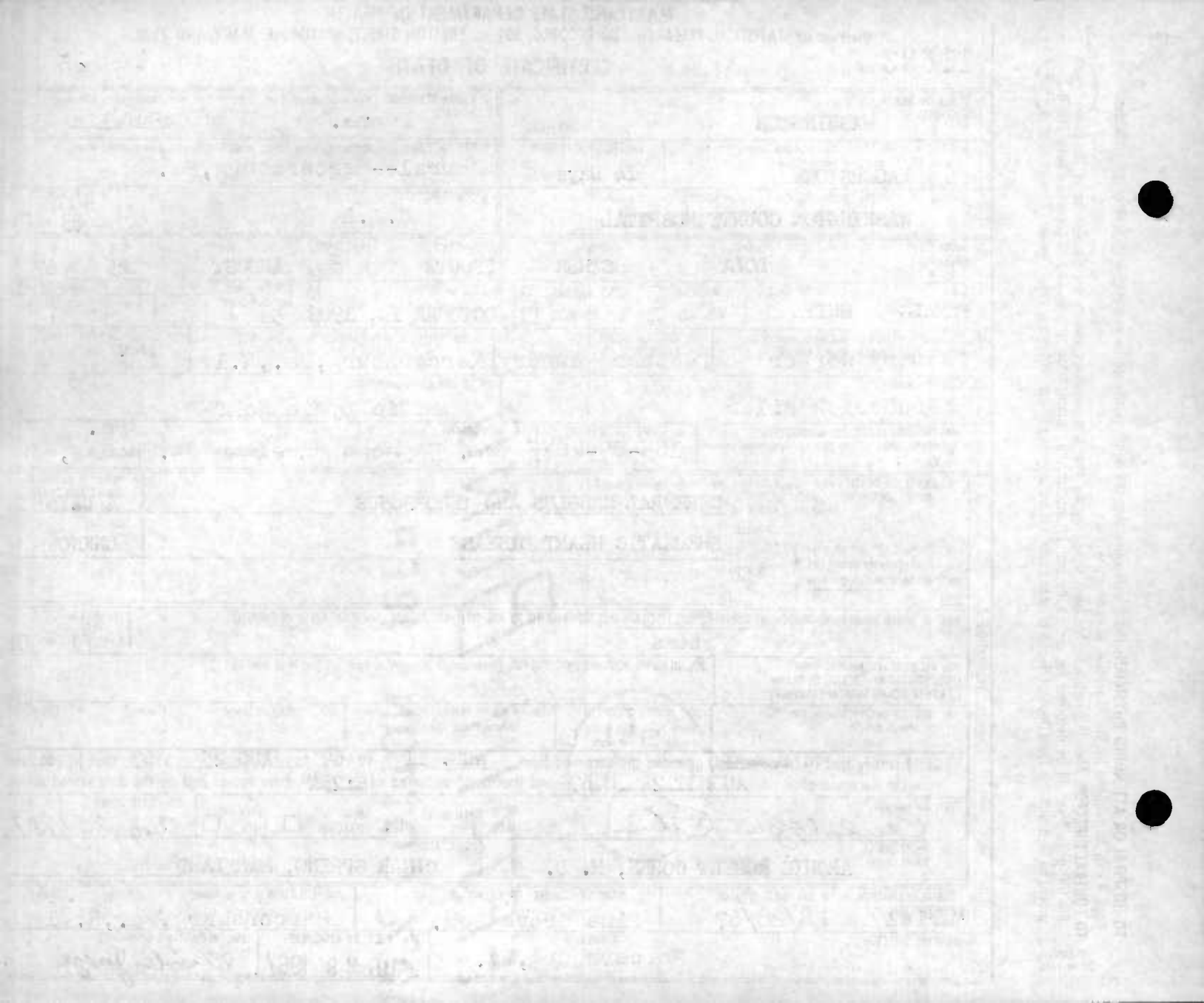
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11633

CERTIFICATE OF DEATH

11645

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 14 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Mercersburg, Pa. d. STREET ADDRESS R.D.1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOLA Middle ESTHER Last PFOUTZ		4. DATE OF DEATH Month AUGUST Day 25 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 10, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Leather Tannery	9. AGE (In years lost birthday) 58 yrs. 11. BIRTHPLACE (County & State, or foreign country) Mercersburg, Pa., R.1 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frederick Filer		14. MOTHER'S MAIDEN NAME Effie Lydia Wolf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 185-09-4045	
17. INFORMANT Mrs. Raymond Eshelman		Address St. Thomas, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS AND THROMBOSUS DUE TO (b) RHEUMATIC HEART DISEASE DUE TO (c) UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUG. 11 , 19 67 , to AUG 25 , 1967, that (I) (we) last saw the deceased alive on AUGUST 24 , 19 67 , and that death occurred at 5:25AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i>		22b. DATE SIGNED Aug. 25. 1967	
22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M. D.		22d. ADDRESS CLEAR SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/28/67	23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cem.	23d. LOCATION (City or Town) (County) (State) Mercersburg, Pa., R.#1
24. FUNERAL DIRECTOR <i>Linger Funeral Home</i>		ADDRESS Mercersburg, Pa.	25a. REC'D BY REGISTRAR AUG 29 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11634

11646

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Fredrick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 254 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route 2, Myersville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Catherine Last Reilly			4. DATE OF DEATH Month Aug. Day 16 Year 1967				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1887	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 10 Days 2	IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Green				14. MOTHER'S MAIDEN NAME Sarah Ann Hoffman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-26-6000		17. INFORMANT Page Routledge, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 9040 DUE TO (b) Secondary + Complications Conditions, if any, which gave rise to immediate cause (a), stating the underlying causa last. DUE TO (c) Subtrochanteric Fracture Rt. Femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 7 days 10 mos.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at Home - Fracture of Rt Femur					
20c. TIME OF INJURY Month, Day, Year 7:00 a.m. Oct 17, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Myersville Fred. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto III				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 8/16/67	
EXAMINER'S NAME (Type) Edward W. Ditto III - 217 W. Wash. St.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE THEREOF Aug. 19, 1967		23c. NAME OF CEMETERY OR CREMATORY United Brethren		23d. LOCATION (City, town, or county) (State) Myersville, Md.	
24. FUNERAL DIRECTOR Paul F. Bittle				ADDRESS Myersville, Md.		25a. REC'D BY REGISTRAR AUG 18 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

254 days

Route 2, Maryland

Aug 16,

Oct 4, 1951

State of Maryland

Edward Green

120-24-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11635		11647	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG POOL		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME		d. STREET ADDRESS BIG POOL	
3. NAME OF DECEASED (Type or print) First Middle Last LONNIE GRANT REPP		4. DATE OF DEATH Month Day Year 8 26 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 31, 1886
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRAKEMAN		10b. KIND OF BUSINESS OR INDUSTRY WM. R. R.	
11. BIRTHPLACE (County & State, or foreign country) COLETA ILL.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM G REPP		14. MOTHER'S MAIDEN NAME EMMA J HART	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705.10.5394	
17. INFORMANT MATTIE E REPP		Address BIG POOL MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Heart Disease DUE TO (c) unknown			INTERVAL BETWEEN ONSET AND DEATH 5 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the deceased) attended the deceased from March 31, 1965 , to August 26, 1967 , that (I) (we) last saw the deceased alive on August 18, 1967 , and that death occurred at 1:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Archie Robert Cohen		22b. DATE SIGNED 08/28/67	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8.29.67	23c. NAME OF CEMETERY OR CREMATORY ST. PAUL	23d. LOCATION (City or Town) (County) (State) WASHINGTON MD.
24. FUNERAL DIRECTOR Howard F. Stone		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 30 1967	

WASHINGTON

MARYLAND

WASHINGTON

812 POOL

LIFE

812 POOL

HOME

GRANT

LOWIE

AUG. 31, 1964

COLLETA LLC

SMITH, R.

GRAHAM

EMMA J. HART

WILLIAM S. REED

705.10.2304 MATTIE S. REED 812 POOL 10.

MONITORING INSTRUCTIONS

MONITORING INSTRUCTIONS

August 30, 1964

1:45 PM

August 31

August 12

08/28/67

ED X

Robert D. [Signature]
Robert D. [Name]
[Address]
[City, State, Zip]

WASHINGTON

ROYAL CLEARING INC

ST. PAUL

8.25.67

BARTAL

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 20 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 38 E. FRANKLIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NAOMI Middle MARGARET Last RINGER		4. DATE OF DEATH Month AUGUST Day 28 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/1901
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of last year, or when if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GORDON McCULLOUGH		14. MOTHER'S MAIDEN NAME CARRIE McCULLOUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 226-28-5417	
17. INFORMANT MR. RICHARD W. RINGER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		22. DATE SIGNED 8-30-67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, or other final disposition BURIAL	23b. DATE THEREOF 8/31/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

WASHINGTON

WASHINGTON

38 E. FRANKLIN ST.

ROOM 1

WHITE WHITE

HOUSEWIFE

GEORGE MACCULLOUGH

NO

20 YRS.

WASHINGTON

38 E. FRANKLIN ST.

MARGARET RINGER

17/1/101

YOUNG

CARLIS SOC. BUREAU

MR. RICHARD W. RINGER

220-28-7417

WASHINGTON

AUGUST 28

U.S.A.

WASHINGTON

8/31/67

ROSE HILL CEN.

WASHINGTON WASH. DC.

SEP 1 1967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11637

CERTIFICATE OF DEATH

11649

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 75.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 198 Tritle Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur V. Rock		4. DATE OF DEATH Month Day Year Aug. 30 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1900
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Manager		10b. KIND OF BUSINESS OR INDUSTRY Graffenburg Inn	11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin F. Rock	
14. MOTHER'S MAIDEN NAME Nettie Verdier		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 173-03-1299		17. INFORMANT Address Penna. Mrs. Flo Rock 198 Tritle Ave., Waynesboro	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary artery dis DUE TO Arteriosclerosis Cardio. Dis. (c) Arteriosclerosis Cardio. Dis.			INTERVAL BETWEEN ONSET AND DEATH 1 day 1 year. 1 year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - old myocardial infarction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 30 Aug 1967 , to 30 Aug 1967 , that (I) (we) last saw the deceased alive on 30 Aug 1967 , and that death occurred at 30 M, from causes and on the date stated above.			
22a. SIGNATURE Richard T. Bistard M.D.		22b. DATE SIGNED 30 Aug 67	
22c. PHYSICIAN'S NAME (Type) Richard T. Bistard		22d. ADDRESS 1135 Latomac Av. Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Burns Hill	23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Penna
24. FUNERAL DIRECTOR Walter y Gae		25a. REC'D BY REGISTRAR SEP 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Franklin

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Waynesboro

198 Tenth Ave.

Washington County Hospital

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30

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Aug. 25, 1900

White

M. J.

U. S. A.

Franklin Co., Penna.

Orleansburg Inn

Restaurant Manager

Matche Verlier

Benjamin F. Rock

198 Tenth Ave., Waynesboro, Penna.

173-03-1299

no

9-15-67 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11650

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MAUGANSVILLE		c. LENGTH OF STAY IN Tb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A FARM NEAR HAGERSTOWN		d. STREET ADDRESS 2100 FAIRFAX ROAD	
3. NAME OF DECEASED (Type or print) GEORGE CRITCHER ROPER, JR.		4. DATE OF DEATH Month AUGUST Day 26 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8, 1915
9. AGE (In years lost birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRANCH MANAGER	
11. BIRTHPLACE (State or foreign country) NORFOLK, VIRGINIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE C. ROPER, SR.		14. MOTHER'S MAIDEN NAME LOUISE TUCKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO. 229-07-7549	
17. INFORMANT MRS. RAY J. ROPER, HAGERSTOWN, MARYLAND.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple crash injuries - 866 X DUE TO involving skull, ribs, spine, upper - lower Ext. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) and lacerations of lungs, heart, liver, DUE TO spleen and intestines (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparent attempt at landing plane in field - crashing in attempt	
20c. TIME OF INJURY Month, Day, Year 10:05 p.m. Aug. 26, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Nr. Maugansville, Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III		22. DATE SIGNED 8/27/67	
EXAMINER'S NAME (Type) EDWARD W. DITTO, III		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 217 W. WASHINGTON ST	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 8/28/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	23d. LOCATION (City or Town) (County) (State) WASHINGTON, 25 D.C.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25. REC'D BY REGISTRAR AUG 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Item #3 Film #G392 9/18/67 ph													
11640													
11652													
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY --							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN tb 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City 69-3							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor						d. STREET ADDRESS 71-44 Yellowstone Blvd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VIOLET (NMN) SCHUBERT						4. DATE OF DEATH Aug 29 1967 19							
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19 1885 82 yrs.		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) New York City N.Y.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Engle						14. MOTHER'S MAIDEN NAME No Record							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 050-09-5471		17. INFORMANT Richard Schubert Old Mill Rd R#3 Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronche Pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Arteriosclerosis - Generalized						INTERVAL BETWEEN ONSET AND DEATH 5 days 2 wks 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Apr 5 , 1964, to Aug 29 , 1967, that (I) (we) last saw the deceased alive on Aug 29 , 1967, and that death occurred at 5:30 AM , from causes and on the date stated above.													
22a. SIGNATURE Lloyd A. Hoffman						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-29-67					
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman, M.D.						22d. ADDRESS 214 N. Potomac St., Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/31/67		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery				23d. LOCATION (City or Town) (County) (State) New York Middle Village Queens C					
24. FUNERAL DIRECTOR Andrew K. Coffman						25a. REC'D BY REGISTRAR SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

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JULY 19 1952

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NO RECORD

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CERTIFICATE OF DEATH

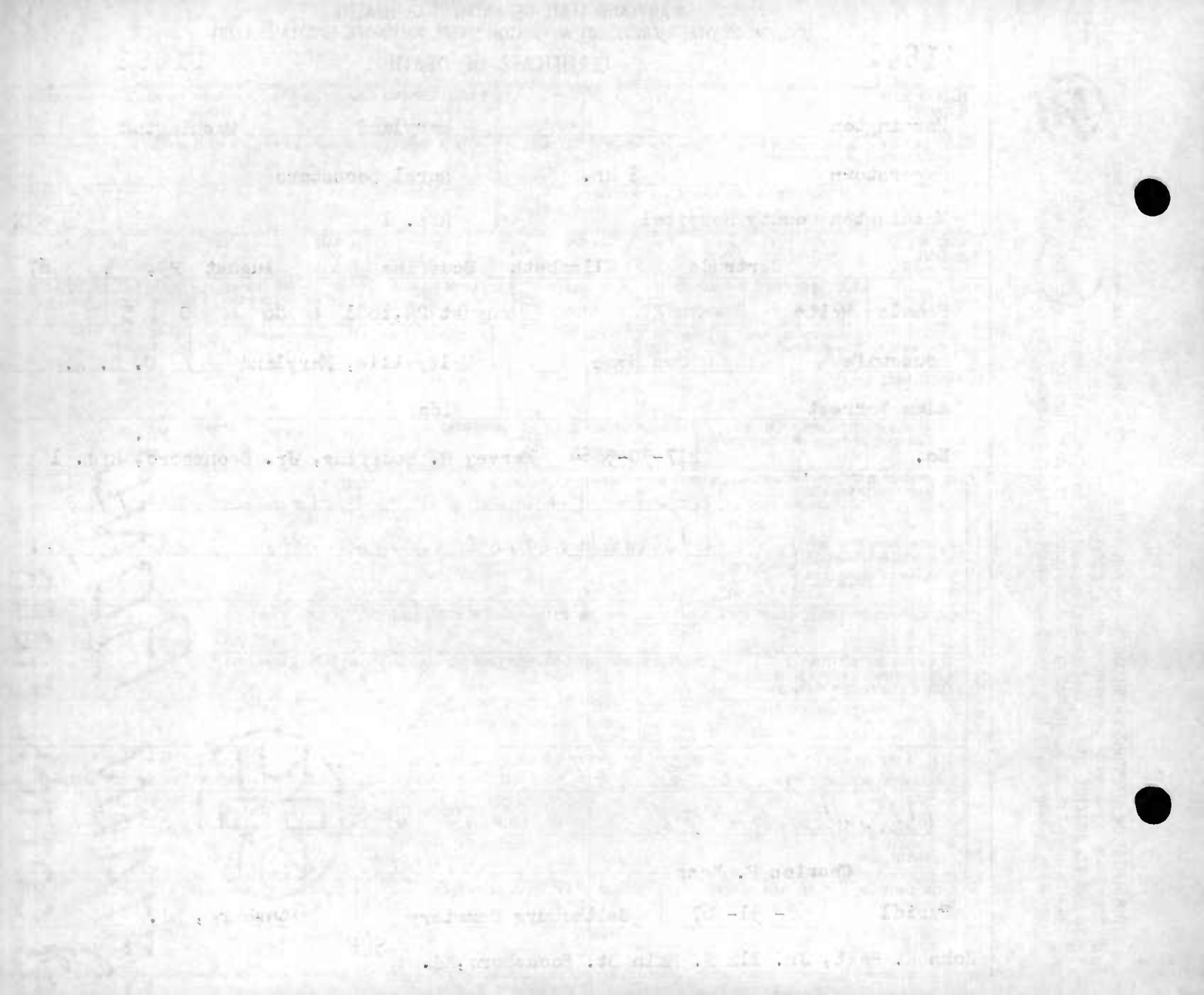
11641

11653

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 1 Hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Rfd. 1	
3. NAME OF DECEASED (Type or print) Gertrude Elizabeth Scuffins		4. DATE OF DEATH Month August Day 29 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1881
9. AGE (In years lost birthday) yrs. 86		10. IF UNDER 1 YEAR Months 0 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Wolfsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Forrest		14. MOTHER'S MAIDEN NAME Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-30-5864	
17. INFORMANT Harvey R. Scuffins, Jr.		Address Md. Boonsboro, Rfd. 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-13 , 19 62 to 8-29 , 19 67 , that (I) (we) last saw the deceased alive on 8-29 , 19 67 , and that death occurred at 12:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess		22b. DATE SIGNED 8-29-67	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess		22d. ADDRESS Smithsburg, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-31-67	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	23d. LOCATION (City or Town) (County) (State) Smithsburg, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr.		25a. REC'D BY REGISTRAR SEP 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11654

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 122 FAIRGROUND AVE.		d. STREET ADDRESS 122 FAIRGROUND AVE.	
3. NAME OF DECEASED (Type or print) First DONALD Middle LEE Last SHADRACH		4. DATE OF DEATH Month AUGUST Day 15 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1919
9. AGE (In years, birthday, yrs.) 48		10. IF UNDER 1 YEAR Months 1 Days 21 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES CLERK		10b. KIND OF BUSINESS OR INDUSTRY PRODUCE CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. GUY SHADRACH		14. MOTHER'S MAIDEN NAME ROSE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) YES		16. SOCIAL SECURITY NO. W.W.#2 214-09-6449	
17. INFORMANT MRS. BETTIE HYSSONG		Address RT #5 HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis + DUE TO 10-15 yrs (c) General arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III , M.D.		22. DATE SIGNED 8/16/67	
EXAMINER'S NAME (Type) Edward W. Ditto, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 217 W. Washington St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REINTERMENT BURIAL	23b. DATE THEREOF 8/17/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W.J. Norman, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 18 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

WASHINGTON

HAYWARD

WASHINGTON

HAYWARD

LINE

HAYWARD

155 BALDWIN AVE.

155 BALDWIN AVE.

AUGUST 12

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WHITE

U.S.A.

HAYWARD

PRODUCE CO.

SEAL CLERK

JOHN SMITH

JOHN SMITH

RECEIVED

21-00-04-9 MAR. 21 1942

21-00-04-9 MAR. 21 1942

RECEIVED

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WASHINGTON

JOHN SMITH

JOHN SMITH

JOHN SMITH

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>11643</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> <p>Item 2 Film C392 8/21/67</p> </div> <div> <p>11655</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Washington</u> MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u></p>				
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><u>Hagerstown</u></p>			<p>c. LENGTH OF STAY IN 1b</p> <p><u>6 6month</u></p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><u>Hagerstown 92 West Washington St.</u></p>				
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p><u>Martin Manor Nursing Home Halfway Hag. Md.</u></p>									
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>RICHARD</u> Middle <u>SHENAN</u> Last <u>SHENAN</u></p>			<p>4. DATE OF DEATH</p> <p>Month <u>Aug.</u> Day <u>15</u> Year <u>19 67</u></p>		<p>e. STREET ADDRESS <u>Martin Manor Nursing Home Halfway Hag. Md.</u></p>				
<p>5. SEX</p> <p><u>Male</u></p>		<p>6. COLOR OR RACE</p> <p><u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p><u>Oct.. 26 1880</u></p>		<p>9. AGE (In years last birthday) <u>86</u> yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Ret'd R.R. POSTAL CLERK</u></p>			<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p><u>R.R.</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country)</p> <p><u>Williamsport Md.</u></p>			<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><u>U.S.A</u></p>	
<p>13. FATHER'S NAME</p> <p><u>David Shehan</u></p>					<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Unknown</u></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p> <p><u>No</u></p>			<p>16. SOCIAL SECURITY NO.</p> <p><u>758-45-6149</u></p>		<p>17. INFORMANT Address <u>Dreshortown Rd. 304 Dreshortown Rd. Penn.</u></p> <p><u>Mrs.. Catherine Marquardt Dresher</u></p>				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u></p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>with metastases</u></p> <p>(c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p><u>Hypertensive Cardiovascular Disease (Arteriosclerotic)</u></p>									<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>Indef.</u></p>
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>			<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>						
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. <u>19</u> p.m.</p>			<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>		
<p>21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 2, 1966</u> to <u>Aug 15, 1967</u>, that (I) (we) last saw the deceased alive on <u>Aug 4 1967</u>, and that death occurred at <u>10:21 M.</u> from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE <u>B.B. Kneisley</u></p>								<p>22b. DATE SIGNED</p>	
<p>22c. PHYSICIAN'S NAME (Type) <u>B.B. KNEISLEY M.D.</u></p>			<p>22d. ADDRESS <u>1486 W. Wash. St. Hagerstown W.</u></p>		<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>				
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>			<p>23b. DATE THEREOF</p> <p><u>Aug.. 18-67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p><u>Greenlawn Cemetery</u></p>		<p>23d. LOCATION (City, town or county) (State)</p> <p><u>Williamsport Md.</u></p>		
<p>24. FUNERAL DIRECTOR ADDRESS</p> <p><u>Jennie E. Leaf #7 Church St. Williamsport Md.</u></p>					<p>25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE</p> <p><u>AUG 18 1967</u> <u>Charles Judge</u></p>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11644

11656

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u> c. LENGTH OF STAY IN lb <u>37 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GATEWAY NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BIG POOL</u> d. STREET ADDRESS <u>RFD-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First Middle Last <u>Shoemaker</u>		4. DATE OF DEATH Month Day Year <u>AUG 2ND 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 16, 1887</u> 9. AGE (In years lost birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAWMILL</u>	11. BIRTHPLACE (County & State, or foreign country) <u>WASH. MD.</u>
13. FATHER'S NAME <u>THOMAS SHOEMAKER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-09-7623</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4200 DUE TO <u>Ath C H F</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Atherosclerotic Heart Disease</u> (c) <u>Atherosclerotic Heart Disease</u>		17. INFORMANT Address <u>GODDIE TAYLOR RD-2 HALE MD.</u> INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-27</u> , 19 <u>65</u> , to <u>6-20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6-20</u> , 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles R. Wheren</u> M.D.		22b. DATE SIGNED <u>8-3-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>AUG 5, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>STONE BRIDGE</u>	23d. LOCATION (City or Town) (County) (State) <u>MILLSTONE WASH. MD.</u>
24. FUNERAL DIRECTOR <u>Donald E. Thompson</u>		25a. REC'D BY REGISTRAR <u>MD AUG 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Yunge</u>			

Attn: Charles R. Warner
C H F
Cardinal Archdiocese

Charles R. Warner
6-20-61
12-27-61
8-3-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11645

CERTIFICATE OF DEATH

11657

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 203 E. Franklin St.			d. STREET ADDRESS 203 E. Franklin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Cletus E. Snodderly			4. DATE OF DEATH Month Aug. Day 21 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1884		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Molder		10b. KIND OF BUSINESS OR INDUSTRY Magnus Metal Co.		11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.	
13. FATHER'S NAME Alfred Snodderly			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 173-03-3128		17. INFORMANT Mrs. Cletus Snodderly
			Address 203 E. Franklin Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Indefinite					INTERVAL BETWEEN ONSET AND DEATH 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive bronchopulmonary disease, advanced					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that <u>(1)</u> (this hospital) attended the deceased from 1961 to August 21, 1967 , that <u>(4)</u> (we) last saw the deceased alive on August 21, 1967 , and that death occurred at 12:30P. M, from causes and on the date stated above.					
22a. SIGNATURE <i>B.B. Kneisley</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/22/67	
22c. PHYSICIAN'S NAME (Type) B.B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/1967		23c. NAME OF CEMETERY OR CREMATORY Green Hill	
23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa.					
24. FUNERAL DIRECTOR <i>Walter J. Guax</i>		ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR AUG 24 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11646

11658

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN Yr 16 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1839 GILBERT AVENUE		d. STREET ADDRESS 1839 GILBERT AVENUE	
3. NAME OF DECEASED (Type or print) First EDITH Middle HELENE Last SOMERVILLE		4. DATE OF DEATH Month AUGUST Day 30 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 14, 1901
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FORSTER		14. MOTHER'S MAIDEN NAME KATHERINE WEIGAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. MARGARET D. THOMPSON, HAGERSTOWN, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardio Vascular DUE TO (b) Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) EDWARD W. DITTO, JR. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/1/67	
23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY,		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, ALLEGANY, MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR SEP 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		26. DATE SIGNED 8/31/67	

8-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

11647

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11659

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 Weeks					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 25 Penn St.					
3. NAME OF DECEASED (Type or print) First Harry Middle M. Last Staley				4. DATE OF DEATH Month Aug. Day 24 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1895			
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Waynesboro Pa.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Stephen W. Staley				14. MOTHER'S MAIDEN NAME Anna Mary Mosser					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 214-09-1514A		17. INFORMANT William H. Staley, Address Hagerstown Md., Route #6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Kidney failure DUE TO (c) Adenocarcinoma Prostate								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE Enrique Garazo				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/24/1967			
22c. PHYSICIAN'S NAME (Type) ENRIQUE GARAZO				22d. ADDRESS Washington County Hosp Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/27/67		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City, town or county) (State) Waynesboro, Franklin Co. Pa.			
24. FUNERAL DIRECTOR Walter Z. Shove, ADDRESS Waynesboro Pa.				25a. REC'D BY REGISTRAR AUG 28 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



No. 211-09-12114 William H. Sealey, Hazleton Md., Route 6
 Stephen W. Sealey
 Barber
 Male White X
 May 7, 1892 75
 Aug. 24 07
 25 Penn St.
 Hazleton Pa.
 U.S.A.
 Anna Mary Hower
 Hazleton Md., Route 6
 Hazleton Md., Route 6

Partial 8/27/67 Green Hill
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 Hazleton Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11660

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 10 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK		d. STREET ADDRESS RFD #2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CO. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDDY CLEATUS STARLIPER		4. DATE OF DEATH Month AUGUST Day 18 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/1939
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY ORCHARD	
11. BIRTHPLACE (County & State, or foreign country) FULTON CO., PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEROY W. STARLIPER		14. MOTHER'S MAIDEN NAME RENTHA SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-36-2376	
17. INFORMANT LEONA I. STARLIPER RD.#2, HANCOCK, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Melanoma, Pulmonary, etc DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Melanoma, Malignant, Skin of Abdomen DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year + 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 8 , 19 67 , to Aug 18 , 19 67 that (I) (we) last saw the deceased alive on Aug 18 , 19 67 , and that death occurred at 2:46 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard V. Hauver		22b. DATE SIGNED Aug. 20, '67	
22c. PHYSICIAN'S NAME (Type) Richard V. Hauver		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/21/67	
23c. NAME OF CEMETERY OR CREMATORY ANTIOCH CHRISTIAN		23d. LOCATION (City or Town) (County) (State) FULTON CO. PENNSYLVANIA	
24. FUNERAL DIRECTOR Howard J. Leone		25a. REC'D BY REGISTRAR AUG 22 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jones			

NOTES AND CORRECTIONS

CHAJYBAM

NOTHING IS AWAY

RURAL HANDBOOK

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div>1</div> <div>2</div>											
<div>11649</div> <div>11661</div>											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						d. STREET ADDRESS RFD 2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Annie Middle Maud Last Stevenson						4. DATE OF DEATH Month August Day 7 Year 1967					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 21, 1902		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner				10b. KIND OF BUSINESS OR INDUSTRY trucking industry		11. BIRTHPLACE (County & State, or foreign country) Elizabeth City, N.C.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John N. Gibbs						14. MOTHER'S MAIDEN NAME Minnie Reasons					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 091-01-1249		17. INFORMANT Address Leonard Gibbs, Smithsburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia 733x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple rib fractures (c) osteoporosis marked + rheumatoid arthritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) anemia INTERVAL BETWEEN ONSET AND DEATH 1 week months years											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 17 Aug , 19 67 , to death , 19 67 , that (I) (we) last saw the deceased alive on 17 Aug , 19 67 , and that death occurred at 11 M, from the causes and on the date stated above.											
22a. SIGNATURE John C. Stauffer						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Dr. John C. Stauffer						22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-10-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR AUG 14 1967		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

Washington

Washington County Hospital

John S. [unclear]

John S. [unclear]

John S. [unclear]

John S. [unclear]

John S. [unclear]

John S. [unclear]

John S. [unclear]

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John S. [unclear]

John S. [unclear]

John S. [unclear]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11650

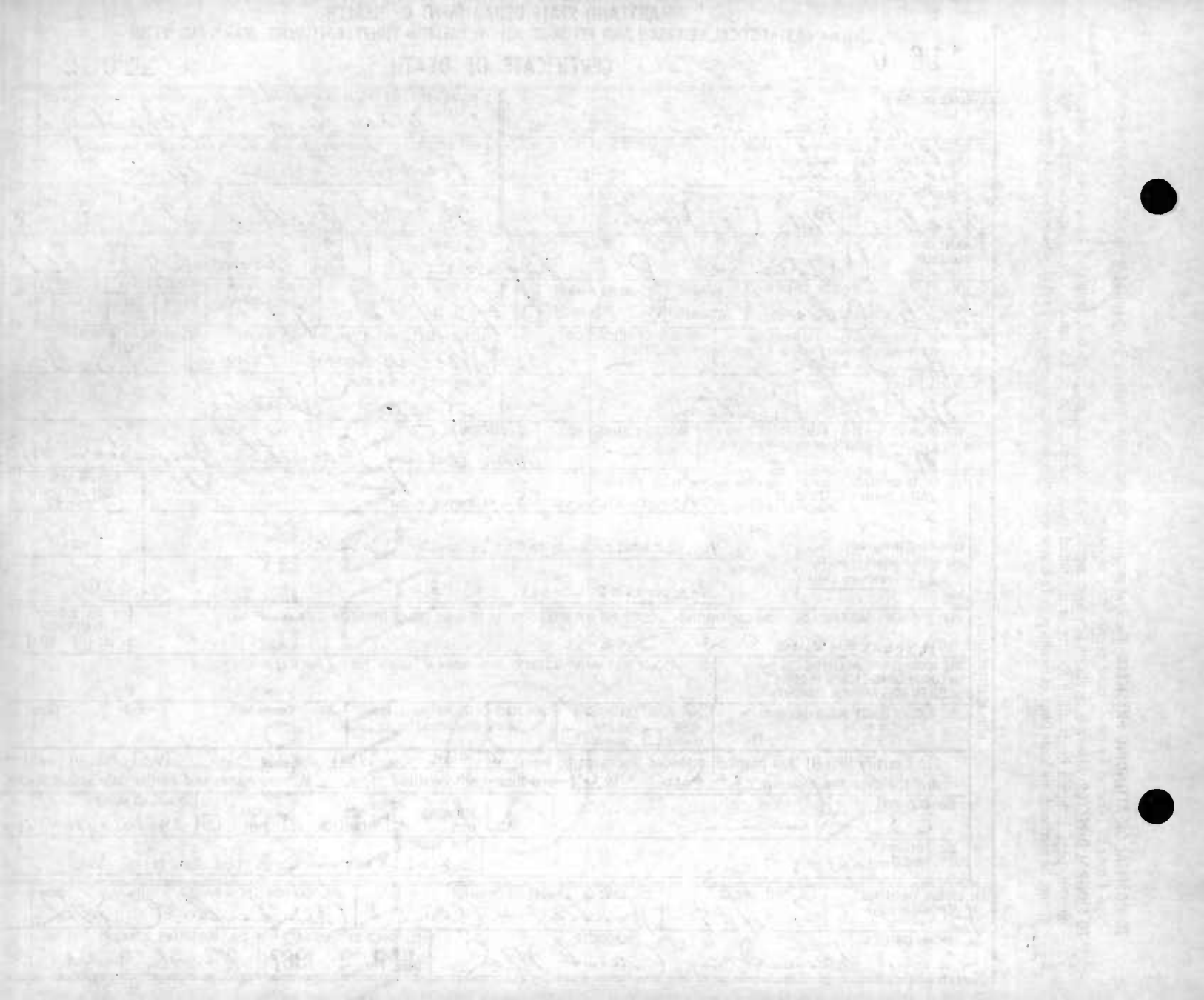
CERTIFICATE OF DEATH

11662

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. Co. Hosp.</u>				d. STREET ADDRESS <u>209 W. Bethel St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine P. Taylor</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/22/88</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wellsburg Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson Preston</u>				14. MOTHER'S MAIDEN NAME <u>Liza Stutz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Daisy Bennett Hagerstown Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>Atherosclerosis, Gen.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Yes.</u> <u>Yes.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic CV Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>16 Feb</u> , 19 <u>67</u> , to <u>29 Aug</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>28 Aug</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>29 August 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>W N FENDER</u>	
22d. ADDRESS <u>218 N. Potomac St., Hagerstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland Md.</u>	
24. FUNERAL DIRECTOR <u>Lewis Stein Inc., Cumb. Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



11651

CERTIFICATE OF DEATH

11663

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capessburg</u>		c. LENGTH OF STAY-IN 1b <u>34 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington County Hosp.</u>		d. STREET ADDRESS <u>R.D. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>ANN</u> Last <u>THOMAS</u>		4. DATE OF DEATH <u>Aug. 23</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1884</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mercersburg, Pa. R. 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Hohn Baker</u>		14. MOTHER'S MAIDEN NAME <u>Aminda Pulschrover</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Clay May, Mercersburg, Pa. R. 3</u>		Address <u>Mercersburg, Pa. R. 3</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection of lung</u> DUE TO <u>465X</u> (b) <u>Pulmonary embolus</u> DUE TO <u>" "</u> (c) <u>Phlebotomiasis</u> DUE TO <u>" "</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) <u>Diarrhea of colon. Colostomy 8/5/67</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 30, 1967</u> to <u>Aug. 23, 1967</u> that (I) <u>was</u> lost saw the deceased alive on <u>Aug. 23, 1967</u> and that death occurred at <u>2:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William C. Beverman</u>		22b. DATE SIGNED <u>8/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Beverman</u>		22d. ADDRESS <u>Mercersburg, Pa.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Mercersburg, Pa. R. 1</u>
24. FUNERAL DIRECTOR <u>J.M. Bringer</u>		25a. RECEIVED BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Mercersburg, Pa.</u>		DATE <u>AUG 29 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11652					11664				
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan (Rural)			c. LENGTH OF STAY IN 1b Entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Dargan)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harpers Ferry RFD #1 Md.					d. STREET ADDRESS Harpers Ferry RFD #1 Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jeanette		First Middle Carletta		Last Tucker		4. DATE OF DEATH Month 8 Day 14 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-3-28		9. AGE (in years last birthday) 38 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Washington, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jesse Ingram					14. MOTHER'S MAIDEN NAME Margaret Giffin				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Charles Harry Tucker, Dargan, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease								INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 7, 1961, to August 14, 1967, that (I) (we) last saw the deceased alive on August 14, 1967, and that death occurred at 4 P. M. from the causes and on the date stated above.									
22a. SIGNATURE Joseph Secondary					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 8.15.67	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph Secondary					22d. ADDRESS Boonsboro, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8-17-67		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION (City, town or county) (State) Sharpsburg, Md.		
24. FUNERAL DIRECTOR Adrian Britton Leaf Funeral Homes					ADDRESS Williamsport, Md.		25a. REC'D BY REGISTRAR DATE AUG 17 1967		
					25b. REGISTRAR'S SIGNATURE John J. Jones				

STATE OF OHIO

IN SENATE,
January 1st, 1891.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1890.

ALBION, OHIO:
PUBLISHED BY
J. W. FARMER & SONS,
PRINTERS,
1891.

12, 1890.
J. W. FARMER & SONS,
PRINTERS,
ALBION, OHIO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11653

CERTIFICATE OF DEATH

11665

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Jacob Hugh Warrenfeltz			4. DATE OF DEATH Month Aug. Day 2 Year 87		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12 1900		9. AGE (In years last birthday) yrs. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Broker		11. BIRTHPLACE (County & State, or foreign country) May Texas	
13. FATHER'S NAME Jacob W Warrenfeltz			14. MOTHER'S MAIDEN NAME Eleanor Foster		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-4866		17. INFORMANT Mrs. Bernadette W Warrenfeltz Highfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphatic Leukemia DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1-12 , 19 56 , to 8-2 , 19 67 , that (I) (we) last saw the deceased alive on 8-2 19 67 , and that death occurred at 6:30 p.m. , from causes and on the date stated above					
22a. SIGNATURE Charles F. Hess			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-3-67
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.			22d. ADDRESS Smithsburg, Maryland 21783		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 5 67	23c. NAME OF CEMETERY OR CREMATORY Cavetown Reform Cemetery		23d. LOCATION (City or Town) (County) (State) Cavetown Wash. Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home			25a. REC'D BY REGISTRAR DATE AUG 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11654					11666				
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 27 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 293 Frederick St.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 293 Frederick St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First JOSEPH Middle VINCENT Last WASILIUS, SR.			4. DATE OF DEATH Month August Day 5 Year 1967						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1918		9. AGE (In years last birthday) 49 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic			10b. KIND OF BUSINESS OR INDUSTRY aircraft mfg.		11. BIRTHPLACE (County & State, or foreign country) Mahanoy City, Pa.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Wasilius					14. MOTHER'S MAIDEN NAME Elizabeth Gelcius				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW II			16. SOCIAL SECURITY NO. 214-14-6960		17. INFORMANT Vivian Wasilius, Hagerston, Md. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO (b) Arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive C-V Disease								INTERVAL BETWEEN ONSET AND DEATH 8-9 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3-31 , 1962 , to 5 Aug , 1967 , that (I) (we) last saw the deceased alive on 3 July , 1967 , and that death occurred at 5:4 A.M. from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					22b. DATE SIGNED 5 August 67				
22c. PHYSICIAN'S NAME (Type) W. N. FENDER					22d. ADDRESS 218 N. Potomac St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 8-8-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md. ADDRESS					25a. REC'D BY REGISTRAR AUG 9 1967		25b. REGISTRAR'S SIGNATURE [Signature]		

U.S. DEPARTMENT OF JUSTICE

Washington

Division

Washington

Department

37 years

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11655

11667

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Mos	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Mt Lena	
3. NAME OF DECEASED (Type or print) EDWARD LEWIS WEAVER		4. DATE OF DEATH Month Day Year August 21 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1 1897
9. AGE (In years birth day) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Orchard	
11. BIRTHPLACE (County & State, or foreign country) Luray page Co Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Weaver		14. MOTHER'S MAIDEN NAME Susan Sowers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 230-30-9225	
17. INFORMANT Mrs Betty Blickenstaff		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) chronic pyelonephritis DUE TO (c) chronic cystitis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 6 mos 1-2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) probable carcinoma of uterus with metastases			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John J. Donoghue		22b. DATE SIGNED 8-22-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. RECEIVED BY REGISTRAR AUG 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

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UNITED STATES OF AMERICA
T. J. HARRIS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11656		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11668	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>26 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>322 W. Howard St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Conrad</u> Last <u>Weigle</u>		4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Oct. 9, 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homes</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harrisburg, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Conrad K. Weigle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-03-9392</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mr. Paul H. Shaner 247 S. Potomac St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>HYPERTENSIVE-ARTERIOSCLEROTIC C.V. DISEASE</u> DUE TO (c) <u>PULMONARY EMPHYSEMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-12 HRS.</u>		Yrs. <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMPHYSEMA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1</u> , 19 <u>66</u> , to <u>12 Aug.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>24 July</u> , 19 <u>67</u> , and that death occurred at <u>8:49 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>W. N. FENDER</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>14 Aug. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u>		22d. ADDRESS <u>218 N. Potomac St. HAGERSTOWN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
23d. LOCATION (City or Town) <u>Hagerstown</u>		(County) <u>Washington</u>		(State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

STATE OF TEXAS

Name	Age	Sex	Race	Religion
John Doe	35	Male	White	Protestant
Jane Doe	32	Female	White	Catholic
Robert Doe	38	Male	White	Methodist
Mary Doe	30	Female	White	Baptist
James Doe	33	Male	White	Presbyterian
Elizabeth Doe	31	Female	White	Anglican
William Doe	36	Male	White	Lutheran
Margaret Doe	29	Female	White	Quaker
Charles Doe	34	Male	White	Unitarian
Anna Doe	28	Female	White	Jewish
Thomas Doe	37	Male	White	Muslim
Sophia Doe	27	Female	White	Hindu
Daniel Doe	39	Male	White	Buddhist
Olivia Doe	26	Female	White	Sikh
Benjamin Doe	40	Male	White	Jain
Isabella Doe	25	Female	White	Tibetan
Elijah Doe	41	Male	White	Vajrayana
Charlotte Doe	24	Female	White	Zen
Lucas Doe	42	Male	White	Theravada
Amelia Doe	23	Female	White	Mahayana
Nathan Doe	43	Male	White	Pure Land
Evelyn Doe	22	Female	White	Nichiren
Oscar Doe	44	Male	White	Jodo Shin
Victoria Doe	21	Female	White	Pure Land
Isaac Doe	45	Male	White	Pure Land
Grace Doe	20	Female	White	Pure Land
Caleb Doe	46	Male	White	Pure Land
Lillian Doe	19	Female	White	Pure Land

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11657		11669	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 79 WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle MAY Last WOLFE		4. DATE OF DEATH Month AUGUST Day 21 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 4, 1885
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		9b. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) CHICAGO, ILLINOIS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 232-52-7019A	
17. INFORMANT MR. RALPH E. WOLFE, 1822 GILBERT AVENUE, HAGERSTOWN, MARYLAND.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Arterio sclerosis, generalized DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 6, 1967 , to Aug. 21, 1967 that (I) (we) last saw the deceased alive on Aug. 21, 1967 , and that death occurred at 10:30 p.m. from causes on the date stated above.			
22a. SIGNATURE George Jennings		22b. DATE SIGNED 8/22/67	
22c. PHYSICIAN'S NAME (Type) GEORGE JENNINGS, M.D.		22d. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 8/22/67	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	23d. LOCATION (City or Town) (County) (State) WALKERTON, ST. JOSEPH, IND.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR AUG 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

Count

Continued

8/22/67

Aug 21 67
James
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